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CONTENTS

The Prevention of Neuro-Syphilis.....	265
J. G. MARTEHS, M.D., Dayton, Ohio.....	
The Modern Treatment of Acne.....	267
IRWIN C. SUTTON, M.D., Hollywood, Cal.	
Two Cases of Long Neglected Congenital Club Feet.—Operative Correction.....	268
IRWIN BALENSWEIG, M.D., New York.....	
Nasal Bleeding Due to a Foreign Body....	269
CHARLES ROSENBAUM, M.D., New York.....	
Troubled Waters.....	270
JOHN J. A. O'REILLY, Brooklyn, N. Y.	
A Case of Pyloric Obstruction Illustrating the Diagnostic Value of the Duodenal Tube.....	271
HENRY A. RAFSKY, M.D., New York.....	

Defense Day.....	272
HENRY CLARK COE, M.D., New York.....	
The Seven Glass Test in Urological Diagnostics.....	273
VICTOR COX PEDERSEN, M.D., New York.....	
Acquired Characters.....	275
CASPER L. REDFIELD, Chicago, Ill.....	
Suggestions for Venereal Patients.....	277
G. MORGAN MUREN, M.D., New York.....	
Team Play for the Benefit of the Patient..	280
JANET M. GEISTER, R. N., New York.....	
Unraveling the Cancer Knot.....	281
HARRISON TAYLOR CRONE, M.D., New York.....	

EDITORIAL.

The Yearly Index.....	283
Mind and Medicine.....	283
From Under the Southern Cross.....	283
A Serious Problem.....	284
The American College of Surgeons.....	284

MISCELLANY.

A Letter and Its Answer.....	284
Needed in Self Defense.....	285

THE PHYSICIAN'S LIBRARY. 286

PUBLIC HEALTH 287

DIAGNOSIS & TREATMENT 288

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The Prevention of Neuro-Syphilis

J. G. MARTHENS, M.D.

Dayton, Ohio

During the past few years the number of neuro-syphilitic cases has increased. There are two apparent reasons for this condition:

I—The improvement in our diagnostic ability to recognize neuro-syphilis early.

II—The insufficient treatment of the primary and early secondary stage with arsphenamine.

From our work we have made three classifications of neuro-syphilis, which is divided into four stages according to symptoms.

I—The Ambulatory or Office Patient

These patients are working daily, perhaps the only complaint is a head-ache or a tired feeling. They do not have their usual "pep."

On examination few neuro-logical signs may be present, as a slight inequality or rigidity of the pupils. Perhaps some speech defect. The blood Wassermann is four plus, the spinal fluid Wassermann one or two plus with the other phases negative.

This type of case with intensive intravenous treatment with the arsphenamines followed by mercury rubs or mercury intravenously and increasing doses of potassium iodide will clear up. The treatment should be in courses with a rest interval and continued over years.

Spinal treatment in this group is not necessary. The spinal fluid will become negative as well as the blood Wassermann and continue so.

II—The So-Called Cerebro-Spinal Type

In this group the neuro-logical symptoms are more advanced. The blood Wassermann is four plus. The spinal fluid Wassermann strongly positive. There is a higher reduction in the colloidal gold, a marked increase in number of cells, often 175 and higher, and an increase in the globulin.

Intravenous treatment with arsphenamine followed by three or four intra-spinal treatments of a pooled arsphenamized fortified serum (which I will describe

later) will result in a negative Wassermann of both the blood and spinal fluid, a flat gold curve, normal cell count and negative globulin.

The laboratory findings will go hand in hand with the improved condition of the patient. This improvement can be held by regulated courses of salvarsan intravenously, followed by mercury rubs and potassium iodide as in the first group.

III—Paresis

This is divided into the acute and chronic type. The acute type I believe is due to little treatment. This is verified as the age of the greater percentage of the patients admitted to the hospital in the past few years has been between twenty and thirty-five years.

The interval between the initial lesion and the onset of neuro-syphilitic symptoms is greatly decreased. It has been possible to obtain a history of some arsphenamine treatment in each case.

In this group there is no evidence of tolerance to the spirocheta. The clinical symptoms are of the acute type: all the neurological signs of paresis or cerebro-spinal lesions are evident. They present a picture of an acute infectious disease. They are evidently suffering from an overwhelming invasion of the spirocheta, which must be counteracted.

The above group present a marked contrast to the other type of paretics, who are past middle age and present the clinical evidence of neuro-syphilis in a chronic or quiescent form.

The treatment of syphilis is the prevention of neuro-syphilis. I am becoming to believe more and more that neuro syphilis can be prevented. The patient must be instructed in regard to his disease, that one series of treatment is not sufficient, but many series are necessary and a negative Wassermann after a few treatments means little. Perhaps the blood is negative. Is the spinal fluid negative? We know that the spinal fluid in the late chancre stage can be involved, and in a high per

cent of cases in the early secondary stage. No case of syphilis should be dismissed before a lumbar puncture is performed and the spinal fluid sent to the laboratory for a Wassermann, colloidal gold and globulin test, together with a cell count.

After paresis has developed our mode of treatment is different. Each patient as usual is given a thorough physical examination, any possible foci of infection as the tonsils or teeth are removed. The elimination of waste products from the bowels must be watched, as these patients have a tendency toward constipation and also retention of urine, or the reverse may be present and they will soil themselves constantly, having lost control of the sphincter muscles. A blood Wassermann is made and a lumbar puncture performer and the spinal fluid tests for the cell count, globulin, colloidal gold and Wassermann made before treatment is started.

Early in the work arsphenamine was given weekly for six doses intravenously: the following week the above treatment was followed the next day, by an intraspinal treatment of a fortified salvarsanized serum.

The weekly intravenous treatment of arsphenamine had no effect on this group of cases. They would continue in the same excited condition, and no improvement would appear until the spinal treatment was given in the seventh week. This improvement in the symptoms after the spinal treatment led to a modification of the method.

The day after the first intravenous injection of arsphenamine the spinal treatment of a pooled salvarsanized fortified serum was given. It was remarkable the improvement in these cases, the excited stage abated, the patient became more quiet and often the psychosis cleared up. The intravenous treatment was continued weekly but the spinal treatment was given every two weeks. After six years experience, I find it is not advisable to give a spinal treatment more often.

For two years this pooled arsphenaminized serum has been employed. During that time no reaction, paralysis or deaths have occurred. This serum is a modification of the fortified salvarsanized serum of Fordyce, (*Am. Jour. of Syph.*, 1919, iv., 337) and superior to the plain salvarsanized serum. Early in the work the method of Fordyce was used.

One half hour after the patient has been given an intravenous injection of arsphenamine, 45 to 60 c. c. of blood is drawn from a vein in the forearm into dry sterile 15 c. c. centrifuge tubes. These are placed in the ice box for several hours after which time they are centrifuged for ten minutes. The serum is poured off into other sterile centrifuged tubes and again centrifuged for the second time or oftener if necessary, until all the red cells are excluded. Serums from twenty to twenty-five patients who have received intensive intravenous treatment are poured into a common beaker and thoroughly mixed. Thus we have a pooled arsphenaminized serum, twelve c. c. of this serum is placed in sterile serologic tubes and closed with an inverted sterile no-hole antiseptic nipple and placed in a water bath at 56 per cent C., for one-half hour for inactivation.

One hour before the patient is to be treated intraspinally the serum is fortified with a dose of arsphenamine. The old salvarsan is used, 0.5 gm. of this drug is added to 150 c. c. of warm sterile freshly distilled water and then sodium hydroxide added to make the solution slightly alkaline. Ten c. c. of this solution diluted to 35 c. c. with 0.5 saline makes a solution of which each c. c. represents one milligram of the drug. The minimum dose is 0.5 mg., the maximum 1.0 mg. The required dosage is placed in the serum, inactivated again for twenty minutes and is ready for use. It is possible always to keep a supply of this serum in the ice box. We do not use any serum over one week old.

After the spinal treatment the patient goes to bed. The first twenty-four hours the foot of the bed is raised on eight-inch blocks and no pillow permitted. At the end of twenty-four hours the foot of the bed is lowered and the patient permitted to have a pillow. At the end of forty-eight hours the patient may get up. This method has controlled any pain in the head or legs following the spinal treatment and makes it unnecessary to give a narcotic to relieve such conditions. In the evening of the day of the spinal treatment some patients have a temperature of 101 per cent to 102 per cent F., but it is normal the next morning.

The initial course of treatment consists of sixteen neoarsphenamine injections and ten spinal treatments; at the end of this course daily rubs of mercury are given and potassium iodide by mouth, this continues for one month.

After this course a rest period of three months is given, then the intravenous course of six treatments followed by mercury rubs, and potassium iodide is again given and repeated every three months.

The Swift Ellis method of salvarsanized serum, the mercurialized serum, the increasing dose of arsphenamine in a saline solution intraspinally and hypotonic saline solution have been tried only to be discontinued.

Two complications occur at times during or after a course of treatment has been completed—jaundice and an arsphenamine dermatitis. Both these conditions will respond to intravenous treatments of sodium thiosulphate. The administration is as follows: 0.3 gm. of sodium thiosulphate is given intravenously; the following day 0.45 gm.; the third day, 0.6; the fourth day, 0.9; the sixth day, 1.2 and the eighth day 1.0. At times it will be necessary to repeat the large doses every two days for a longer period. In dermatitis due to arsphenamine along with the intravenous treatment of sodium thiosulphate, it is advisable to give by mouth 15 gm. of sodium thio-sulphate well diluted with water.

The clinical symptoms improve first in this group. The first change noticed in the laboratory findings is an improvement in the colloidal gold test, combined with a lower cell count and a negative globulin. In fact the change in the reduction of the gold test seems to go hand in hand with the improved clinical condition of the patient.

The blood Wassermann and the spinal fluid Wassermann tests are the last to change. Even in the cases that have been discharged from the hospital and returned to work the Wassermann tests of both the blood and spinal fluid has remained positive with few exceptions.

The patient must be treated as an individual, the clinical symptoms, the improvement watched and then compare that condition with the laboratory findings. The diet should be nourishing, well regulated exercise is necessary. These patients need encouragement, for as they improve they realize their condition. The larger per cent will co-operate with you for they have learned what to expect if they do not.

These patients have a tendency to over-eat and along with this constipation will develop. If this fault is not corrected it will bring on a relapse which I have had two experiences. Correcting the diet and relieving the constipation has made it possible for these patients to continue at work without a relapse again.

In the second group, the patients are much older. They are all past middle-age. In this class we do not see the acute violent symptoms. The initial lesion dates back many years if one is at all able to obtain a history of an infection.

(Concluded on page 282)

The Modern Treatment of Acne

IRWIN C. SUTTON, M.D.
Hollywood, Calif.

Results obtained by the modern treatment of acne show in a concrete manner the progress made in the last few years in dermatologic treatment. Severe acne approached sycosis barbae in difficulty of handling by the older methods, consisting of the application of lotions, soaps and peeling pastes.

The lesions of acne consist of plugged sebaceous glands with subsequent infection of their contents and associated suppuration of the surrounding tissue. In the presence of occlusion of the glands, infection is more or less obvious, but the cause of the primary plugging is probably due to a change in consistency of the sebum plus an increase in quantity of secretion. The cause of increased activity of the glands, occurring as it usually does at puberty and lasting for about ten years, is probably buried in endocrinology. In the light of our present knowledge, however, the administration of various combinations of gland extracts is not attended with any striking results.

As far as their response to treatment is concerned, acne cases usually resolve into two groups; those in which little treatment gives a good response, and those in which the utmost persistence and resourcefulness are necessary to produce permanent cure. It is the latter class which tries the metal of the dermatologist, but with care and attention to detail, good results can practically always be obtained.

For clarity I have divided the discussion of acne treatment into two parts; the local treatment and the general measures aimed at the correction of defects in the health. The first is of supreme importance.

Absolutely essential for good cosmetic results, is the proper removal of the comedones and the expression of pus from the lesions by the physician, and the adoption by the patient of a definite hygienic regime for the skin. In severe cases it may be necessary to go over the face with a comedone "knife" three or four times a week to remove drying plugs and pus. The removal of pus from deep lesions is best accomplished by a straight Hagadorn needle, as suggested by Campbell, or by a quick stab with a sharp cataract knife. The follicle should be opened exactly in the center and where there is much edema it will be necessary to use a hand lens to find the mouth of the gland. Liberal swabbing with sponges soaked with alcohol serve to keep the field clean during operation. A little gentle pressure applied with the thumbs by a pulling apart motion may be necessary, but pinching and squeezing a deep pustule invariably leaves a large irritated pocket which may heal with a deep scar.

In the proper care of the skin it is necessary to instruct patients to leave their lesions alone and to forego the exquisite torture of picking and handling them. In fact, some case of acne approach neurotic excoriations in the matter of the large factitial element present in the dermatologic picture. Nightly facial shampoos with tincture of green soap after the manner of a barber, "working up" a lather followed by the application of a sulphur lotion in the form of Lotio Alba or Vlemincx's solution is a plan of home treatment advised by my former Chief, Dr. John Stokes of the Mayo Clinic. Vlemincx's solution is made as follows:

Lime	3ss
Sublimed Sulphur	3i
Distilled water	5X

Boil down to six ounces and filter.

The less irritating Lotio Alba is made as follows:

Sulphurated potash	grains XV
Zinc Sulphate	grains XV
Water	3 IV

This preparation is not very stable and should not be used longer than two weeks since its efficiency depends on the presence of finely precipitated sulphur from the sulphides. Both these lotions should always be well shaken before applying at night. After several days, the skin becomes irritated and a fine branny desquamation occurs. Unguentum Aquae Rosea may be substituted for several nights when this occurs, and the lotions resumed after several days.

Ultra-violet light therapy is very popular at present in the treatment of acne, but unless a severe dermatitis is produced little headway is made. Personally, I have never seen lasting results from its exhibition when used alone, but in combination with the x-rays it is sometimes a valuable aid. My preference is for the carbon-arc lamp which is much richer in ultra-violet light.

While there are many methods of technic used in the employment of the x-rays, the fractional dose method of MacKee is safe, speedy and gives almost uniformly good results. One-eighth to one-quarter of a skin unit given by a standardized machine for from ten to fifteen weekly treatments usually suffices. Of course it must be remembered that no irritating applications should be made.

Aside from the direct or local treatment of acne, many factors enter into successful management of the cases so affected. Sugar intolerance may be present in some cases and pustulation only stopped on a low or carbohydrate free diet. A surprisingly large number of patients are affected by protein sensitivity. In these there is usually evidence of a vasomotor instability and a large urticarial element present in the lesions. These patients should be tested out for protein sensitization toward foods and external irritants and the offending protein eliminated if possible. Vaccines as usually employed are disappointing. The removal of infected tonsils is sometimes followed by improvement in the acne.

Non-specific protein therapy in the form of intradermal injections of a purified milk-albumin preparation, aolan, has given good results in my hands. The method of application is simple: every five days an intradermal injection is made. The flexor surface of the forearm is cleansed with alcohol, which is allowed to evaporate. With the thumb of the operator's left hand, pulling down on the skin toward the wrist, the needle is slowly inserted with the bevel facing up and the plunger forced slowly down. If rightly performed, a whitish wheal is made in the skin. Two such wheals, each containing from two to three drops of aolan, constitutes a treatment. In order not to go too far, it is a good plan to start the needle going before the bevel has completely disappeared.

X-ray is perhaps the most valuable single agent at the disposal of the dermatologist. It is entirely possible to cure the disease without recourse to any other methods. Such an attitude is to be condemned, for acne is a complex dermatologic disorder due to many causes and with diverse expressions of underlying pathology. Search for the etiologic factors should always be made with an attempt to remove or correct them if possible. Milk therapy in the form of aolan is a valuable adjunct to modern treatment and vies with hygiene of the skin in importance of cosmetic results and prevention of relapse.

Two Cases of Long Neglected Congenital Club Feet—Operative Correction

IRVIN BALENSWEIG, B.S., M.D.

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New York

Congenital equine-varus although quite common in infancy, and early childhood, is a rarity in adult life, as a large percentage are recognized and receive treatment early. As a result of the post-war influx of immigrants, it has been the good fortune of the author, to meet with two adults, thirty-five and twenty-nine years of age respectively, suffering from the effects of neglected deformed feet, of the congenital type.

It is the sole intention of the author to present these cases with a view towards impressing the profession with the fact that something can be done for these unfortunates. The only advice previously given was that of submitting to amputation of the feet. This treatment is wholly unnecessary as well as costly in the end.

The etiology, pathology, etc., is very well dealt with in the standard orthopedic text books, and need not be discussed here.

Case Reports:

B. Z., male, age 35, was first seen at the Cornell Clinic January, 1923, because of a persistent and annoying discharge from the outer aspect of the right foot, for which he had been receiving antiluetic treatment for the past two years, the entire length of time that he has been in this country.

Examination at that time showed a well developed man, walking about awkwardly with the aid of a cane, in a manner described as "reel gait." The only other deformities present were those of an extra digit on the outer aspect of both hands. The lower extremities were atrophied with the feet maintained in an attitude of exaggerated varus, and equinus of the os-calcii, the weight being borne on the outer half of the dorsum of the feet. The feet were very much shortened, and rotated and presented an extra toe on their lateral aspects. The weight bearing surfaces exhibited large bursae, underlying calloused skin, that of the right side being infected and exuding sero-purulent material.

On February 6, 1923, the patient was admitted to the Hospital for the Ruptured and Crippled where the infected bursa was excised, the foot stretched and a plaster applied with a fenestrum over the operative area. The plaster was changed from time to time and on July 9, 1923, the patient was again admitted to the Hospital for correction of the deformities, it requiring all these months to convince him that something more could be done. During his last stay of three months in the hospital, the following operative procedures were carried out.

On July 10th, the left foot was operated upon and both the astragalus and scaphoid were removed, the foot displaced backward on the leg, and rotated forward. One week later, the

foot was again stretched and plaster re-applied, this procedure being repeated on August 3rd.

August 31st—A wedge resection was performed on the outer aspect of the foot, including the distal row of tarsal bones and the bases of the metatarsals. The deformity was over-corrected by this procedure, and maintained by the application of a plaster paris foot bandage.

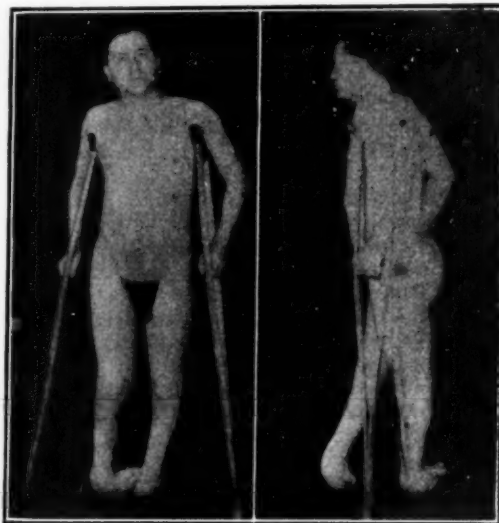


Fig. 1.—Case No. 1.—Before operation, anterior view.

Fig. 2.—Case No. 1.—Before operation, side view.

The right foot—A stretching and application of plaster paris foot bandage was performed on July 10th and one week later the wound at the site of the infected bursa, previously described, was revised by undermining the edges for a distance of one-half inch and closed. This was necessary because of failure of the original wound to heal. Complete healing finally took place by August 7th, and on August 13th the astragalus and scaphoid were excised and the deformity completely corrected. Plaster of paris foot bandage applied maintaining the correction.

Patient was discharged from the hospital on October 8th, three months after admission, walking about with the aid of two canes. Two months later, all plaster was discarded, and custom-made shoes applied. When last seen, July, 1924, the feet were

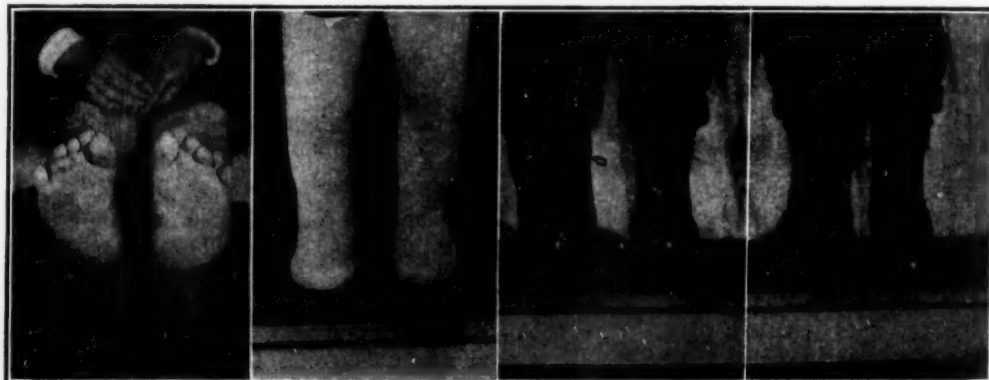


Fig. 3.—Case No. 1.—After operation.

Fig. 4.—Case No. 1.—After operation.

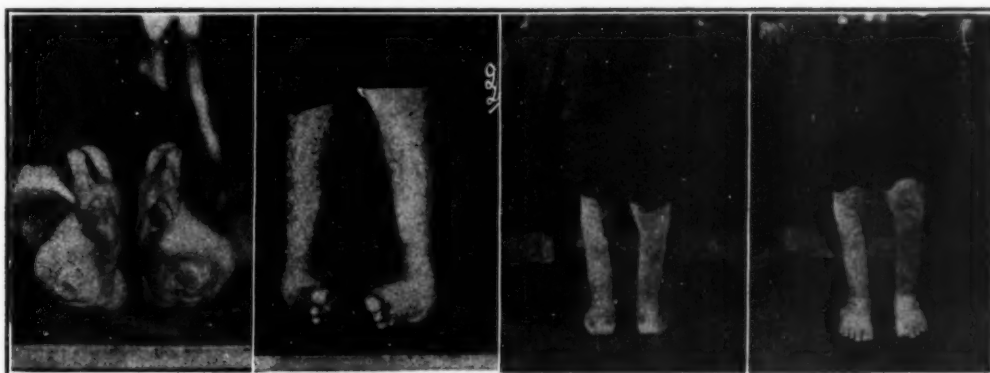


Fig. 5.—Case No. 2.—Before operation.

found to have maintained their corrected attitudes, and the patient's gait is markedly improved.

Case No. 2—S. R., male, age 29, presented himself at the Out Patient Clinic of the Hospital for the Ruptured and Crippled, December, 1923, requesting correction of his deformed feet.

December 15, 1923—Admission notes made by Dr. Royal Whitman, "Patient is in good general condition. Presents typical complete untreated bilateral club-feet, with rotation of the patellae and knock knees."

On December 17th, the right foot was operated upon, and the following was performed: Astragalectomy after the manner of Dr. Whitman with displacement of the foot backward on the leg, and the deformity partially corrected. A plaster paris foot bandage was applied, maintaining the correction. Three weeks later, the foot was manipulated, and further correction obtained and re-bandaged. Some two weeks later, a wedge resection was performed on the outer aspect of the foot, completely correcting the deformity.

The left foot—Operation performed by Dr. Royal Whitman on December 31st—the foot was manipulated, partially correcting the deformity, and maintaining the foot in the corrected attitude by plaster of paris bandages. Two weeks later the following procedures were carried out: astragalectomy, scaphoidectomy, wedge resection on the outer side of the foot, excision of bursa, and tenotomy of the tendo-achilles. The foot was then held in an over corrected attitude, and a plaster of paris bandage applied.

Five weeks later, the foot was enclosed in a walking plaster and on March 17th, three months after admission to the hospital, the patient was discharged walking about with the aid of crutches.

On May 3rd, the plaster was completely discarded, and stock shoes were fitted. When last seen, July 31st, 1924, the result was found to be most satisfactory, insofar as the feet have maintained their corrected attitudes, and the gait markedly improved.

Fig. 6.—Case No. 2.—After operation.

The treatment above outlined should be limited only to the very severe untreated cases of congenital club feet, for it is well known that correction in younger individuals can be obtained by repeated stretchings, aided by soft tissue operations, such as teno-

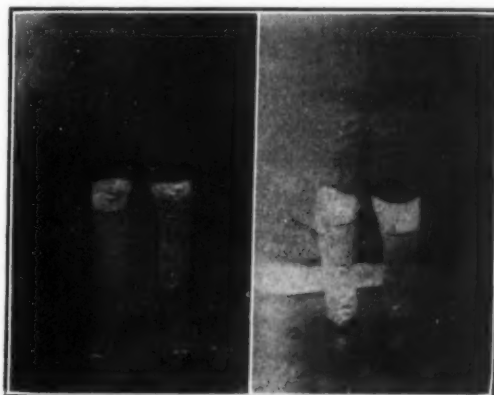


Fig. 7.—Case No. 2.—After operation.

tomy of the tendo-achilles, posterior capsulotomy of the ankle joint, cutting of the plantar fascia, Ober operation, accompanied by an occasional wedge resection.

1215 Madison Ave.

NASAL BLEEDING DUE TO A FOREIGN BODY

CHARLES ROSENBAUM, M.D.
New York

The tendency to make a diagnosis from what seems an obvious cause without a complete examination is often misleading as illustrated by the case described below.

Epistaxis has numerous etiological factors which differ widely, and treatment must be directed toward the etiological factor for relief. There are local causes, underlying predisposing constitutional factors and vicarious performance of suspended process elsewhere. Among the local causes especially with children is the presence of a foreign body in the nose. The history elicits no information, as the child has forgotten about the foreign body and bleeding comes weeks after the event.

A. R. six years old was brought to my office with the history of continuous small hemorrhages for the last two months. While the amount of blood was small in quantity its continuous character finally induced the mother to seek medical aid. The family physician noticed the tonsils and adenoids and recommended their removal as a cure for the nasal bleeding.

In spite of the hypertrophied tonsils the child was in robust health so the possibility of a constitutional underlying cause was immediately ruled out. Adenoids ought only to be blamed if everything else is negative. On looking into the right nostril with a headlight and mirror a foreign body was seen and felt with a probe, wedged against the middle turbinate. After cocaine anesthesia and shrinkage with adrenaline the foreign body was removed without any pain.

(Concluded on page 288)

Troubled Waters

JOHN J. A. O'REILLY, M.D.,
Brooklyn, N. Y.

I

Whether strain of "Dies Irae" or the lilt of Hiawatha
Fits your mood when you are reading, let your thoughts of
family duty,
And your duty to your Order and your duty to the Nation,
Guide the spirit of your reading of the facts—that, in your
County,
You may sense the REAL proportions of the "King can do no
wrong stuff";
Learn the fact that 'mongst your leaders there are those who
train with wreckers;
Bore-within, preach Registration as the be all and the end all
Of the State's relief from Cultists—just exactly as they chanted,
Back in Nineteen-hundred-nineteen Hymns of Welfare, Hymns
of Uplift,
And the great and glorious dawning of the Brotherhood of Man-
kind
When "Calamity of sickness" would be soon annihilated
Through Compulsory Health Insurance, with a Panel of Phy-
sicians.

II

Get me right—not every Doctor who believes in Registration
Is a crook—no, no, far from it; some are "easy," some class-
conscious,
Some believe they're hearing Gospel when at State or County
meetings
An aristocratic Rightman, with a Lawyer at his Rightside,
Makes a speech and scolds the Doctors who "begrudge two
paltry dollars"
And a "little inconvenience" for Re-Registration yearly.
But, you'll grant me, every story has two sides—this one's a
three-some,
Yours . . . the People's . . . and the Wreckers'. But, the
People and your Order
Are identical in interest. If you think the plans of Wreckers
In Triangle-economic is Hypotheneuse and equal
In its squarings to the People AND their Agencies of Healing,
Stop right here and read no farther—you are hopeless—or a
dumb-bell.

III

If, however, you are eager to get ALL the facts, then know you
That when propagandists tricky found the Doctors of Kings
County
Had aroused the VOTING People to the imminence of danger
From Compulsory Health Insurance—with its Complement—
A PANEL
Of the Agencies of Healing—Doctors, Dentists, Druggists,
Nurses,
Institutions, drugs and dressing, they became enraged and
threatened
If they failed on Health Insurance they would make us take
State Medicine;
If they won, they'd bring the Doctors "down to heel" though
measures legal
That would vest in Layman's Bureau the DISCRETIONARY
POWER
To refuse or grant the Doctor right to Register and practice.
There's in EQUITY a Maxim:—"He who speaks not when he's
threatened,
Can't be heard to speak when injured." It's the Principle of
Laches.

IV

There's the threat; here's its fulfilment. In the year of Nine-
teen-twenty
Your Re-Registration, yearly, was provided by a measure
Introduced in the Assembly by a Legislator—Kenyon
It was beaten through the Doctors and the People of Kings
County;
Then, again, in Two-and-twenty, Bloomfield Senate Bill was
beaten,
And in Twenty-three the BORERS were deterred because we
threatened
To go out among our People and to warn them of betrayal
By the Borsers-from-withinside aiding Wreckers from the out-
side.
By one-sided Editorials, by suppression of objections;
By deceit, half-truths and duress; by abusing power of office
To deny a free, frank hearing on the Carroll-Lattin measure;
Branding Paul Reveres Bolshevik, and obstructionists, disloyal.

V

Then they quoted many Counties as supporting, as endorsing
The Re-Registration measure; let me show you how they did it:—

For Example, New York County has three thousand Doctor-
members;
There were seventy at a meeting; six and thirty were in favor;
There were thirty-four against it! I was there and asked for
hearing;
Did I get it? "No! No! Nora." 'T would be perilous permit-
ting
Light of fact to shine from rostrum into minds of men of reason,
Lest they wreck design and purpose of Comitia Minora,
Chloroformer-extraordinary to the Master of Phillipics.
That's the reason up-State Doctors are amazed to learn the
purpose,
That's the reason why at Roch'ster, forty-three Del'gates quizzed
by me
Showed but one who knew 'twas Collars and not Dollars we
were fighting.

VI

Collars? said I? Aye, and Nose-ring, for the tricky propa-
gandists
Of Compuls'ry Health Insurance owed a debt to Birth-Con-
trollists
For their aid in Nineteen-nineteen! the Appellate Courts de-
cisions
In the case of Margaret Sanger, had knocked "prop" from
propaganda,
So the Wreckers from the outside and the Borsers-from-within-
side
Have, in every bill, since Kenyon's, hung repealing crape (or
brackets)
On the only inhibitions of Abortion-Contraception¹
By the Doctor, as an adjunct, to a Communistic Clinic
To insure, by birth reduction, Proletarian Domination.
Stop to think—this Contraception has already made a killing,
Two-and-four-tenths-to-the-thousand, in round numbers quarter
million,²
Is the loss in babes, per Annum, since the Congress passed their
measure³

VII

It must be a source of pleasure to the Devil to see Doctors
Pose, with hand on Code of Ethics, yet be sponsors of this
measure
That will Panelize the Doctors; that will Cattleize the People;
That will paralyze the Nation; that will Eunuchize coitus;
How the Devil he must chuckle at the purblind hero-worship
Of their leaders, by the Doctors, so that bait, hook, line and
sinker
Is obediently swallowed when they hear their Master speaking.
Thomas Jefferson, in warning, said to founders of this Nation,
"Over-confidence in leaders is, of despotism, parent:
In jealousy, not confidence, lies the strength and power of Na-
tions."
Had this warning not been heeded, back in Nineteen-hundred-
nineteen,
You'd be like your English brothers, Panel Doctors; Social
strikers.

VIII

On the question of Narcotics, and likewise of alcoholics;
You recall, distinguished leaders gummed the cards; again, at
Boston,
In the Spring of one-and-twenty, there was forged a vicious
weapon,
That was used by Mr. Sanders, Indiana man in Congress,
To confound protesting Doctors at the Sheppard-Towner hear-
ing⁴
And help pass that wretched measure that has helped to shrink
our birth-rate.
Please, for Heaven's sake, dear Doctor, be as perspicacious,
nearly,
With this Uplift stuff and Welfare as you are with some new
theory
That's advanced in Science of Med'cin'. Get both sides of
every story;
Use your judgment, use your reason; don't be swayed by hero-
worship;
Get the facts and keep before you, every minute while you're
thinking,
Those two threats I have recited; don't forget what's meant by
LACHES.

¹ Sec. 170-c, 170-d Medical Practice Act—Sec. 174, subdivision 2-b
of the Carroll-Lattin Annual Re-Registration Bill.

² U. S. Public Health Service Report, September 5, 1924.

³ Sheppard-Towner Maternity Bill enacted Nov. 21, 1921.

⁴ A. M. A. State Medicine Resolution before the (Winslow) Con-
gressional Committee on Interstate and Foreign Commerce, July, 1921.
405 Union Street.

A Case of Pyloric Obstruction Illustrating the Diagnostic Value of the Duodenal Tube*

HENRY A. RAFSKY, M.D.

New York

Peptic ulcers with pyloric obstructions are not very rare. We see them often enough. But a peptic ulcer with a pyloric obstruction that is not visualized fluoroscopically or radiographically and is detected by other clinical means is rather uncommon.

I report this case to emphasize the fact that a duodenal tube can be of inestimable value to us when

The physical examination was as follows:

General Appearance—a well-developed and well-nourished white male about 35 years of age, weighing 125 lbs. and about 5' 6" tall. No joint deformity or spinal curvature.

Skin—dark, warm, elastic; copper colored pigmentation over chest and ending in point at umbilicus and also extending over back especially over right side, pigmentation ends about lumbar region.

Glands—slight inguinal enlargement on right side.

Reflexes—pupils react to light and accommodation. Knee jerks sluggish.

Head—eyes and ears negative; no nasal obstruction. Teeth in poor condition; most of upper set missing. Gums diseased; breath foul.

Neck—negative for glandular enlargement.

Chest—heart: in normal position; not localized except on up-right posture. No murmurs or adventitious sounds heard. Lungs: a roughened respiratory sound heard in interscapular space, upon left side. Vocal tactile fremitus normal. Percussion notes normal; no rales.

Abdomen—marked tenderness in epigastrium. Liver slightly enlarged.

Extremities—negative.

Tests—the blood pressure was systolic 82, diastolic 54. The urine showed a trace of albumin at times—otherwise it was negative. The Wasserman was negative. The gastric contents showed Hcl +; acidity = 80; blood—positive; no sarcinae.



Fig. 1.

the x-ray examination not only fails to aid, but has a tendency to mislead one. This brings us back to the stand of the old clinical observer, namely to interpret our clinical findings carefully and not to follow laboratory results blindly.

Patient. J. P., age 38, born in Russia, married, a carpenter by occupation, consulted Dr. Max Einhorn on December 29, 1923. The man gave the following history:

Family and previous history were negative. The present illness dated back to five years ago when patient began to have abdominal pains mostly in right upper quadrate. This pain occasionally began on the left side and extended across to the right where it settled and remained. It was sharp and burning in character and usually came on regularly about two hours after meals, persisting for one to two hours, then remitting only to return after the next meal. Eating relieved the pain. Vomiting never occurred unless induced. There was no heartburn. The attacks of pain first came on and lasted for several weeks, then remitted for several months and recurred again for several weeks. Patient had an average period of three to six months relief from attacks of pain. Past six months patient has had the pain more or less constantly. His appetite was always good. The bowels were constipated. He had lost about 30 pounds in 7 months.

Dr. Einhorn made a diagnosis of duodenal ulcer with probable obstruction and referred the man to the Lexington Hospital. The patient entered the hospital January 15, 1924, and was placed under the care of Dr. Einhorn and myself.



Fig. 2.

But the amount of fluid extracted from the gastric contents was very large in amount. The retention meal showed slight evidence of gastric retention. The string test was positive for a duodenal ulcer.

The fluoroscopic and radiographic examination revealed a persistent deformity of the first portion of the duodenum. (Fig. 1.) There was no evidence of gastric retention at the end of six hours. (Fig. 2.)

From the above history and findings the diagnosis of duodenal ulcer was correct. From the above we also felt that a patent pylorus was present.

(Concluded on page 285)

* Read before the Harlem Medical Society of New York, April 2, 1924.

Cure of Angina Pectoris By Mechanical Means

ERNEST KINGSOTE, M.B., C.M., EDIN.

HON. PHYSICIAN TO ST. PANCRAS DISPENSARY,

London

Hitherto the line of treatment of angina pectoris has been merely precautionary and palliative; thus, Price in his "Textbook of Medicine," published in 1923 is compelled to state that the treatment of angina pectoris resolves itself into two factors. The warding off of the attack and its relief. He is able to make no suggestion of any attempt permanently to relieve the condition.

Poynton in a lecture delivered at the Great Ormond Street Hospital for Sick Children, London, and published in the *British Medical Journal*, June 2, 1923, began by saying, "In this lecture I will consider a question which I believe to be, at present, the most practical in the whole range of the study of heart disease—the possibility of preventive measures (*cardiac treatment being for the moment, almost at a standstill.*)"

Jonnesco and some other surgeons have even proceeded to such heroic measures as division of the sympathetic in the neck for the relief of the pain in angina pectoris, but Professor Wenckenbach of Vienna in a lecture before the Royal College of Physicians in London, 1924, condemned surgical interference as impracticable and uttered the last word on the subject by saying that treatment could only be precautionary and palliative. Such being the case 'twere time indeed that an attempt should be made to relieve this painful and dangerous condition.

I claim that such an attempt has been made, and a successful one at that.

In a letter to the *British Medical Journal*, Dec. 25, 1920, I pointed out that the conditions of angina pectoris and fatty degeneration of the heart (they are frequently concurrent) were dependent, mainly, on two factors, dilatation of the heart and loss of the normal negative pressure in the chest, thus allowing the positive pressure and giving rise to the painful and untoward symptoms and accounting for the agony experienced by the sufferers during an attack.

A very common complaint made by the patient is that he "feels as if his heart were screwed up in a vice." This, in fact, is exactly what is happening. The engorged heart is struggling against the fixed ribs. The upper chest, owing to the heart breathlessness, has become less mobile than normal and the ribs do not retire before the struggling heart, hence the "vice-like" feeling.

I also pointed out that the painful attacks could always be relieved by certain mechanical movements, and that permanently. The patient in the majority of instances, is able to follow his ordinary occupation and even become active again. Two hundred successful cases were quoted in corroboration of this. Stress was laid on the necessity for accurate estimation of the shape, size and position of the heart and of the relative proportion of the respiratory movements.

The enlarged and fatty heart was reduced by the so-called Nauheim resisted exercises. The acquired positive pressure in the chest was banished and the beneficial normal negative pressure was reinstalled by certain breathing exercises demonstrated by the writer at the annual meeting of the American Electro-Therapeutic Society in New York City in 1913 and before the Medical Society of London in 1920, the title being "Selected Breathing Exercises (Kings-

cote) for the Reproduction of the Chest Excursion and the restoration of Lung Elasticity in Emphysema and allied conditions."

As the result of many years' work on these obtruse propositions we are now able to promise the sufferer from angina pectoris that the painful attacks shall cease (being able, as we are, to eliminate pressure in the chest. In the majority of cases, the danger zone is left behind as the enlarged fatty heart gradually becomes diminished in size and, with stronger beats, pump more blood to its own walls. The fat globules disappear and the musculature grows again.*

5 Gloucester Place, Portman Square.

*The whole argument is set forth at length in the author's work "Movement in Organic Disease." Baillière, Tindall & Cox, 8 Henrietta Street, Covent Garden, London; William Wood & Company, 51 Fifth Avenue, New York.

Defense Day

It is not known to the general public, so quietly and unostentatiously was this important plan carried out, that six millions of men throughout the United States, civilian and military, registered voluntarily to serve this country in an emergency. The medical profession was foremost in "mobilizing" in this peaceful way and I was proud to find the Army Building, where I reported for duty, swarming with my confrères, young and old, in and out of uniform,—all cheerfully laying their business to prove their allegiance to the colors, which we have taken the oath to serve in peace, as well as in war. I confess that every pessimistic thought that I had previously had regarding the "patriotism" (that word so often misused) of my countrymen was banished forever and I felt in my heart the truth of the familiar lines in Scott's *Marmion*:

"Where is the coward who would not dare
To fight for such a land!"

To many this may seem a passing sentiment; to one who has been born and bred as a soldier it is vital fact. To me it seems self-evident that the privilege, not duty, to serve the country in war is identical with the franchise. We are not citizens of the Republic on any other terms, and I am glad to know that this creed is that of so many in our profession. Having once taken the solemn oath, it binds us "until death do us part." It is stronger than the marriage vow, which seems to be a loose bond in these days.

So many of the younger generation have forgotten, or wish to forget, their experiences in the late war. I cannot forget them, for I regard them as the most precious in all my life. The three "R's,"—rank, ribbons and reputation—mean little to us now. The outstanding fact is that thirty thousand doctors served in the U. S. Army and that they ought to be proud of it, as their children and their children's children will be in after years. Whether their services were recognized as fully as they thought they ought to have been, or not, does not matter, they were on the job. We had learned in civil life to "endure hardness as a good soldier," and we did endure it, in camp and field, and in the less spectacular, but equally important, work of transacting routine office business."

I do not profess to understand the psychology of this generation; that of the so-called "pacifist" I have never tried to analyze.

Defense Day was a great success and we had a share in it. We may never see another war in which we take the same altruistic attitude that we did in the Great War, but the country is safe from any aggressive nation that can show such a record as our's.

H. C. C.

The Seven-Glass Test in Urological Diagnostics

VICTOR COX PEDERSEN, A.M., M.D., F.A.C.S.

New York

The determination of the source of pus and shreds in the urine in persistent though small quantity with or without the presence of infectious organisms, has long been one of the most difficult problems for the urologist. The latest advance is the determination of the exact nature of the infecting organism, in contrast with passing satisfaction with the presence or the absence of the gonococcus as such.

My last paper demonstrated this truth by reference to the work of Luys, and the reader is referred to that quotation accordingly. Ever since Thompson evolved the two-glass test for urethral diagnoses thoughtful urologists have recognized that it is entirely misleading in the many cases in which the pus is produced not by the urethral mucosa alone but either by surrounding glands and organs, such as Cowper's glands and the prostate, or by the bladder, ureters and kidneys, which do not connect with the urethra until the sphincter muscle opens. Thus the immediate distinction must be reached between urethral, periurethral and supraurethral pus, all in very strict sense.

One of the basic facts which the general practitioner is apt to overlook is that a urethra, Cowper's gland, or prostate which has been producing very little pus indeed will exude large quantities after or during any manipulation, such as the passage of a catheter, sound or urethroscope. With special attention to the urethroscope it is worthy to note that this fact of disturbance of discharge makes very unreliable the method of endeavoring to secure specimens from the prostatic urethra, through the urethrosopic sheath. The instrument in its passage through the anterior and membranous urethrae will necessarily massage out enough material from the mucous crypts to furnish an abundant specimen, and by having dragged it to the posterior urethra cause a confusion of specimens. The only correction of this mistake possible would be to remove the obdurator, wipe the field clean (which is bacteriologically impossible), return the obdurator to its place, massage the prostate against and in front of the instrument, remove the obdurator again and take the specimen. The trauma of such a manipulation especially in the presence of lurking infection is highly undesirable, and in the opinion of the writer is better omitted than attempted.

Ever since careful consideration of the whole problem settled at least its difficulties, efforts have been made toward solution. No test is without error and some are basically more erroneous than others, as exemplified by the foregoing adverse criticisms of urethrosopic specimens. The definite degree of uncertainty makes the greatest possible caution with any method adopted an insurmountable condition.

In the writer's opinion a multiple glass test is much to be preferred to the urethrosopic test, because it minimizes the interference with natural processes. Multiple glass tests show three groupings: (1) those without irrigation and without dyes, of which the Thompson two-glass test is the original; (2) tests with irrigation and without dyes, of which the author's seven-glass test is after the experience of many years the most reliable; and (3) tests with irrigation and with dyes, exemplified by Krohmeyer's

and Lohnstein's. The third group may be dismissed as too complicated through the capillary action by which dye stuffs travel, to be anything but very confusing. In other words, a dye injected into the urethra for staining specimens in the anterior portion only, will of necessity travel into the membranous and prostatic portions without any known method of control, and hence cause error. Before detailing the technique of the seven-glass test, it is worth while to repeat the tables of simple tests for the meaning of turbidity of the urine as follows. The first table is that of Ultzmann and the second is that of Kidd.

ULTZMANN'S TESTS FOR TURBID URINE

Boiling the upper layer of turbid urine in a test tube

Turbidity				
Vanishes	Increases			Remains unchanged even after addition of acetic acid.
	If due to earthy phosphates, carbonates or pus-corpuscles. Add one or two drops of acetic acid.			
If due to acid urates.	Dimness vanishes with evolution of gas; carbonates.	Dimness vanishes without evolution of gas; phosphates.	Dimness remains unchanged; pus.	The dimming is caused by catarrhal secretion, or by bacteria.

KIDD'S TESTS FOR TURBID URINE

K O H added to the urine

Turbidity		
Vanishes: Uric Acid	Remains: Bacteria	Ropes up: Pus:
	Stirring "swirls" bacteria	Pouring from glass to glass makes ropes

Phosphatic turbidity increases with addition of KOH and may be dispelled at once by addition of acetic acid, as in Ultzmann's table.

The use of these two tables is both practical and efficient, but apparently they are not as familiar to the general practitioner as they should be. The application of the seven-glass test is by no means easy in the sense that it requires patient practice and experience to do it so well that casual errors arising from carelessness are eliminated. Equally true is the fact that it is not so difficult as to prevent the general practitioner from learning and using it. The following quotation from the author's "Textbook of Urology" describes the technique as fully as possible within restricted limits.

"1. The patient must come with the bladder as full as possible, by holding his urine for five hours; the instruments must be carefully adjusted and prepared; the irrigation and massage must be thoroughly done and finally judgment and experience must be brought to the diagnosis of all the glasses arranged in a row.

2. A precaution, antecedent and subsequent to the test and never to be omitted, is the administration of any standard and efficient urinary antiseptic for several days. None is better than a solution of five to ten grains each of benzoate of soda and of one of the formaldehyde-producing drugs to a dram of

water three or four times a day in a glassful of water about two hours after eating.

3. With the patient flat on his back on a table, with shirts rolled up to his armpits and trousers turned down to his knees and with a Wolbarst basin resting on his thighs, the anterior urethra from the bulb forward is gently massaged after suitable cleansing of the foreskin and meatus.

4. A 12 Fr. soft-rubber catheter is gently passed into the urethra to the bulb and then connected with a 150 c.c. Janet-Franck syringe filled with warm, normal salt solution. The bend of the catheter beyond the meatus droops into a sterile glass resting in the basin so that the irrigation of the urethra is readily carried into the glass.

5. While the left hand supports the penis and catheter from change in their relation to each other and to the glass, the right hand irrigates the anterior urethra with the entire contents of the syringe, 150 c.c.

This step secures Glass I or the anterior urethral glass.

6. The urethra is again gently massaged, from the bulb forward, in order to dislodge clinging discharge not brought away by the first massage and irrigation. The irrigation is repeated exactly as before.

This step produces Glass II or the control anterior urethral glass.

7. The patient now passes about one inch of urine into a glass, or more if he has had his bladder as full as directed in the preliminary instructions. The contents of the posterior urethra are in this way carried into the specimen along an anterior canal previously cleared by the two irrigations just described.

This step presents Glass III or the posterior urethral glass.

8. Having thus cleansed the urethra as a whole,

the character of the urine in the bladder must be known and is secured by passing a small rubber catheter into the bladder and drawing off a part or the whole of the contents.

This step collects Glass IV or the bladder glass.

9. The diagnosis is completed by knowing the condition of the secretion of the prostate and seminal vesicles. If the patient still has considerable urine in his bladder massage of these organs is done at once, or with the catheter still in place the bladder is filled with warm normal salt solution and then the catheter is withdrawn and the massage performed.

This step shows Glass V or the massage glass.

The author's seven-glass test consists in adding the following details to those stated.

10. After the bladder glass is secured, the prostate is very carefully massaged with special reference to not touching either seminal vesicles or their ducts as they pass through the middle of the prostate. This may be done with reasonable and satisfactory success by the experienced finger.

This step presents Glass V or the prostatic glass.

11. The bladder is again filled up to the limit of comfort with normal salt solution whose quantity is noted to, say, 200 c.c., and the right seminal vesicle is thoroughly massaged, carefully avoiding the prostate, and then the patient evacuates half his bladder contents (100 c.c.).

This step contains Glass VI or the right vesicular glass.

12. The left seminal vesicle is now massaged as its fellow was and its products flushed out with what remains in the bladder, or if the patient has not divided the contents of the bladder well, more fluid must first be run into the bladder or this vesicle left until the next visit for examination.

This step contains Glass VI or the right seminal vesicular glass.

TABLES OF AUTHOR'S SEVEN-GLASS TEST FINDINGS.

POSTERIOR CHRONIC URETHRITIS WITH PROSTATITIS.							
	I.	II.	III.	IV.	V.	VI.	VII.
Contents of glasses	Clear or few shreds (turbid).	Clear.	Turbid or large shreds or prostatic elements.	Clear.	Turbid, abundant prostatic detritus.	Clear.	Clear.
POSTERIOR CHRONIC URETHRITIS WITH UNILATERAL SEMINAL VESICULITIS.							
Contents of glasses	Clear or few shreds (turbid).	Clear.	Turbid or large shreds; vesicular elements.	Clear.	Clear (few elements from prostate and vesicle).	Clear (slightly turbid).	Turbid; many vesicular shreds.
POSTERIOR CHRONIC URETHRITIS WITH BILATERAL SEMINAL VESICULITIS.							
Contents of glasses	Clear or few shreds (turbid).	Clear.	Turbid; large shreds; vesicular elements.	Clear.	Clear (turbid).	Turbid; many vesicular shreds.	Turbid; many vesicular shreds.
CHRONIC URETHRITIS WITH PROSTATITIS AND UNILATERAL SEMINAL VESICULITIS.							
Contents of glasses	Clear or few shreds (turbid).	Clear.	Turbid or large shreds.	Clear.	Turbid; abundant prostatic elements (seminal vesicular elements).	Clear (slightly turbid).	Abundant seminal vesicular elements.
POSTERIOR CHRONIC URETHRITIS WITH PROSTATITIS AND BILATERAL SEMINAL VESICULITIS.							
Contents of glasses	Clear or few shreds (turbid).	Clear.	Turbid or large shreds; prostatic and vesicular elements.	Clear.	Turbid; abundant prostatic elements (seminal vesicular detritus).	Turbid; seminal vesicular elements.	Turbid; seminal vesicular elements.
POSTERIOR CHRONIC URETHRITIS WITH CYSTITIS.							
Contents of glasses	Clear or few shreds (turbid).	Clear.	Turbid or large shreds.	Turbid; abundant bladder elements.	Clear.	Clear	Clear.

The limitations and cautions of these two tests noted in the introductory paragraph must always be borne in mind. It is well to massage the less diseased seminal vesicle first so that contamination of the contents of the posterior urethra will be limited."

Since the foregoing quotation was written, the writer has given the following instructions to his assistants in learning this method. It should be remembered that the vasa deferentia enter the prostate at the middle of its upper border remain in the middle, and pass parallel with urethra into the colliculus as the ejaculatory ducts. Therefore, if massage of the prostate is confined to the lateral lobes away from any part of the middle line of the gland, the products of the massage will come from the prostate and not from the ejaculatory ducts. Similarly the seminal vesicles are the highest and most lateral objects on the floor of the bladder with ampulla of the vas rather near the middle line. If felt at all, the ureter is half-way between these two objects. These anatomical facts must not be even slightly confused, otherwise the results of the massage will not be good.

A detail which the writer has recently learned is that the right hand should be used for the right vesicle and the left hand for the left vesicle, because the sweep of the finger along the course of the vesicle

and the ampulla of the vas deferens is much more conveniently, thoroughly and deeply made in the radial direction. Hence the change of hands is well worth the trouble it costs.

The accompanying table is made up from actual observations on patients, and illustrates, according to the titles given, suggestive and specimen findings.

It is about ten years since the writer developed the details of this test. The more he uses it, the greater his confidence in it, with due knowledge of its difficulty, full allowances for its possible errors, and conservative interpretation of its findings. It is infallible as a primary index between pus in the urinary organs ending with the bladder and pus in the sexual organs beginning with the posterior urethra. It is almost equally reliable in determining cases of disease in the mucous membrane of the urethra as distinguished from diseases in the prostate gland, and seminal vesicles. When combined with urethroscopy and cystoscopy it gives a final definiteness of conclusion which is most satisfactory. The average patient and especially the intelligent patient usually remarks about as follows: "Well, doctor, I have never been so thoroughly examined before, and I certainly appreciate the value and service of this test to me."

45 W. 9th St.

Acquired Characters

CASPER L. REDFIELD,

Chicago

Back in ante bellum days, a bird breeder in Bremen, Germany, named Reich, started some experiments looking toward improving the singing qualities of his canaries. His method was to employ that "queen of songsters," the nightingale, as tutor for young birds. As only the male nightingale sings, this was a case of using a male queen as a school master. As the nightingale sings for only about two months in the year, Reich reinforced his living teachers by getting phonograph records of the nightingale song. The fact that such records may be bought on the market at the present time is due solely to the fact that Mr. Reich caused them to be made for use in his singing school for canaries.

This singing school was kept in operation during the war under a good many difficulties, but little by little he got canaries which would sing more and more of the nightingale song. His method was to use in-breeding, and, after the first year, to use as pupils only the offspring of birds which had been previously taught. In 1918, for the first time, he got one canary which sang the full and complete nightingale song, and three others which gave a large part of that song. Previous to that, his canaries had adopted only single tones or parts of song from the nightingale. It is to these four, and particularly to that one, that his subsequent success was principally due.

In the years following 1919, rapid progress was made. As more and more beautiful singers were produced, the close in-breeding was gradually discontinued, and nightingales were no longer needed as teachers. The old birds taught the young ones. In January, 1924, Mr. Reich's canaries with the nightingale song won the gold medal at the Federal Exposition at Dresden, and two weeks later another gold medal at Mannheim.

The account of the experiments was written by Dr. H. Dunker of Bremen, who was associated for several years with Mr. Reich in these experiments, and was published in the *Weser-Zeitung* of Bremen. A copy of that paper was sent to me by Professor Johann Plenge of Munster, Germany, and what is here given is taken from a translation of that article. After stating that the results of Reich's work gave him the idea of making a scientific experiment, Dr. Dunker goes on as follows:

"Mr. Reich's birds had acquired a new power and a new song. There was now the question of what the young birds will do when they are raised without a singing teacher. Will they fall back into the old canary song, or will they bring forth elements of the nightingale song without having heard it? Will Weismann's doctrine be sustained, or will there be exhibited an actual inheritance of acquired characters?"

"The experiment has been made and has resulted in a complete success. Two young males of first class descent, but brought up in isolation, give forth typical nightingale songs. One of these, while I am writing this, is singing along side of me a splendid nightingale song,—a song of which no ordinary canary is capable. Where did he get it? He never heard a nightingale sing, nor his parents sing, nor any canary whatsoever. He inherited it. Science and practice have joined hands here and shown that the inheritance of acquired qualities is a possibility."

Here we have a case of the transfer of an hereditary character from one bird to another without the Mendelian operation of hybridization and segregation. The song transferred is specific to the nightingale, and no imaginable amount of Darwinian variation and selection will account for that transfer. There is no reason why the voice of the canary should "vary" toward the voice of the nightingale any more than toward the voice of the oriole or the crow.

This is not a case of the inheritance of a thing learned and remembered. A thing remembered is a non-biological thing, and non-biological things are not biologically inherited. Imitation is something

common to all animals capable of making observations, and in imitating the nightingale song, the young canaries developed their vocal organs in a manner somewhat different from that in which their ancestors had done. It is a biological principle that when an organ is exercised, the powers of that organ increase, and when it is not exercised, the powers decline. When new powers are exercised and old powers not exercised for several generations, a time finally comes when the new powers are greater than the old powers, and the animal naturally acts in a new way. In the case of Mr. Reich's birds, it was more than five years after the beginning of instruction before he got one which would sing the full nightingale song, and another five years before he got one which would sing that way instinctively and not by imitation.

The nightingale song is not simply a single sound which the bird utters when he opens his mouth. It is a series of variable tones which follow each other in succession, and to understand this matter in inheritance we may consider some recent experiments made by Pawlow of Leningrad, formerly called Petrograd and known as St. Petersburg when Mr. Reich began his experiments. Pawlow taught white mice to come to dinner at the ring of a bell. It required 300 repetitions of bell ringing and feeding for those mice to associate the sound of the bell with something to eat. The second generation acquired a similar degree of association in 100 lessons. The third generation acquired it in 30 lessons, the fourth in 10 lessons, and the fifth in 5 lessons.

This has been construed to mean the inheritance of the thing learned, but that is an erroneous idea. It is a physiological relationship in which one operation follows automatically on the heels of another, and is of the widest kind of application in living things. For example, when one smells something good to eat, saliva flows automatically. Such a flow does not occur simply because an odor reaches the olfactory nerves. It occurs only when the odor is of something good to eat, and it is part of our inheritance because our ancestors have associated the two by eating when such odors were in their nostrils. Such association is not useful, and consequently was not established in inheritance by Darwinian selection. As far as usefulness is concerned, such a flow of saliva might very well wait until the food reached the palate.

Other examples would be the walking of a colt or chick immediately after birth. Walking is not a simple operation. It is a very complex series of muscular contractions and relaxations which follow each other in a definite order to produce a definite result. The animal does not know what muscles are operated, and consequently there can be no memory of such sequence of operations. What has occurred has been the establishment of a physiological relationship by continued repetition, and as physiological things are biological, they can be biologically inherited.

When one of Mr. Reich's birds opened his mouth to utter a sound, the sound given forth was that for which the vocal organs were best adjusted at the time the mouth was opened, and that adjustment was determined by the previous practice of those organs, either in that bird or in his immediate ancestors. With one sound given forth, other sounds followed in the sequence in which those organs were adapted to follow, and which had come to this bird by inheritance. Acquired characters are not only the

powers which are developed by exercise, but they also include the linkage of those powers so that operations follow each other automatically in definite sequences.

While the operations of Reich in implanting in one animal a characteristic which is specific to a different animal is a new and novel proceeding carried out in an intelligent and skillful manner, the process of giving a new "instinct" to an animal is not new.

The method employed by Reich to make canaries change from one song to a predetermined other one is identical with the method by which high-speed trotting horses were produced from running stock.

The natural high-speed gait for the horse is the run. The trot is a natural slow-speed gait. Until recently, when a trotting horse was urged to high speed, he would break into a run to relieve the strain on his trotting muscles. But as a trotting race cannot be won at the run, a horse which broke into a run was stopped and started over again at the trot. After several generations in which horses were forced to trot and prevented from running, the trotting muscles became more powerful than the running muscles, and it became easier for such horses to trot than to run. Such horses are known as "instinctive trotters," and will stick to the trot no matter how much they are urged to speed. They no longer run.

We have a history of what occurred in the production of high-speed trotters out of runners, just as we have a history of how canaries were made into nightingale singers. It is also known that every attempt to explain the change in these horses on other grounds than the inheritance of powers developed by exercise involves assumptions known not to be true.

The specific nature of the song of birds corresponds to the specific character of resistance to disease, and Reich's experiments on canaries will help to an understanding of the inheritance of immunity. Being vaccinated against smallpox does not help directly as a protection against typhoid, typhus or tuberculosis, and being vaccinated against typhoid does not protect against measles, mumps or meningitis. In each case in which there is produced a resistance to a disease, that resistance is specific for the disease involved.

There are about as many different diseases in human beings as there are different songs of birds, and if we take all the different animals and plants into consideration, there are about as many different kinds of disease as there are different kinds of sounds which can be produced by living things. They are so numerous that a few billions one way or the other is of small consequence. And for each one of these diseases, the resistance to be provided is specific for the disease. A disease is not a simple item. It is as complex an affair as is the song of a bird, and a resistance to one of these diseases must be as complex as the disease it is to resist.

In current literature there is much said about the "selective death rate" as the means by which a race becomes immune to certain diseases. This means that human beings just vary in resisting power, and that among the different kinds of variations possible, there is a variation without guidance or direction toward the specific resistance required, and that this variation includes all of the complexities of the disease.

(Concluded on page 286)

Suggestions for Venereal Patients

G. MORGAN MUREN, M.D., NEW YORK

Foreword

My first paper with the above title was published in 1902.* It occurred to me that a paper covering the three venereal diseases and their complications, reprints of which could be handed to patients, would be of great help to them in making clear the seriousness of their condition, impressing upon them how much they could do to assist in their ultimate cure, the folly of considering themselves cured when the symptoms ceased, and finally, save much time in an active practice.

The re-writing of this paper is necessary chiefly on account of the changes in the diagnosis and treatment of syphilis that have been made in the past twenty years. Little change has been required in the section on gonorrhea.

I believe that every physician treating venereal diseases should have a similar reprint to hand these patients.

Most medical men believe that it is unwise to discuss with patients the minutiae of their diseases; that it is likely to increase the mental concentration upon the particular ailment, and, if anything, aggravate the condition. While this may be true of most other patients, the good results to be obtained by a thorough understanding of his condition on the part of the venereal patient, will greatly outweigh the short-lived mental distress he may suffer on being told certain positive facts regarding the disease from which he suffers. In this we must not only consider our duty to the patient, but his duty to his relatives, friends and the public at large.

The patient with a disease of this type should consult his physician immediately upon the discovery of suspicious symptoms, such as pain during urination, the appearance of a discharge from the canal of the penis, or sores upon any part of the genitals.

Having decided upon whom to consult, he should remain under the care of one physician if possible. Most men who have had venereal diseases know a physician, or perhaps a druggist, who can cure "clap", etc., or will possibly offer the victim a "favorite prescription". Such advice which is only too freely given can but unsettle him and should not be heeded, as, if the physician originally selected by the patient is a reputable man, his advice as to consulting the specialist will be readily given should that become necessary.

Gonorrheal and syphilitic patients should remember that long after any symptoms which they can appreciate have disappeared, they are a source of danger to others and should remain under their medical adviser's care until discharged by him as cured. During the long tedious treatment of chronic urethral conditions, and especially in the stage of syphilis after all symptoms have disappeared, this is particularly trying, and how he follows this advice will depend largely upon the patient's confidence in his physician.

Gonorrhea

Gonorrhea, or "clap," as it is commonly termed, is a contagious disease, beginning with acute symptoms in the male and running an uncertain course. Regarded by many men as a comparatively simple affliction, they welcome the first few drops somewhat as a matter of course, to discover later, in most cases, its gravity.

The disease is caused by a micro-organism known as the gonococcus. This gains access to the canal of the

penis during sexual intercourse and, remaining apparently dormant for a period varying from three to ten days, or occasionally a little longer, manifests its presence by a burning pain on urination, and by the appearance of a milky discharge from the canal of the penis, at first noticeable only in the morning, but usually becoming so profuse in a few days that some method of protecting the clothing is necessary.

In the beginning a gonorrhea is confined to the first part of the canal, but in ninety per cent of cases it later extends to the deep portion, or posterior urethra (near the bladder), and it is in this location that the germs find access to the canals leading to the testicles and other important structures, producing various complications and lengthening the course of the disease.

Gleet

The large number of chronic gleets, which drift from one physician to another, are representative of this class of cases. The patient when first infected has consulted a medical man who has probably given him an injection and some internal medicine. After a variable period of time his discharge and other active symptoms have ceased and all treatment has been discontinued, without, possibly in some cases with, the consent of his physician. Some time later after a sexual or alcoholic debauch, or possibly without apparent cause, he notices a "morning drop", or it may be a fairly free discharge; he urinates more frequently, has a sense of uneasiness in his urethra, and other symptoms. He has chronic posterior urethritis, probably gonorrheal, and in the great majority of cases his prostrate gland will be found infected with these germs. This condition cannot be cured with injections that the patient can use or by internal medication.

It is in this type of case that the patient should select his medical attendant with care and remain under treatment until pronounced cured by the physician. The individual having gonorrhea in his posterior-urethra and prostrate gland is largely responsible for the spread of the disease, as he so often ceases treatment when his symptoms disappear, the disease remaining uncured.

Simple Urethritis

Simple urethritis may occasionally be contracted from the menstrual flow of the female, or from some irritating vaginal discharge, when no gonococci are present. Usually the symptoms are slight and the discharge moderate in quantity and thin and watery in appearance. It runs a mild course and responds quickly to treatment in most cases. In others, however, it may be very persistent and annoying. The diagnosis between this condition and true gonorrhea can only be made with the microscope. The physician who today would venture a diagnosis without the aid of the microscope should be avoided by the patient as careless, or seriously wanting in common knowledge.

Treatment

In the treatment of gonorrhea and its complications it is particularly desirable to acquaint the patient with the *raison d'être* of each procedure. If he has been treated with hand injections and internal medicines, he should be told, if they are indicated, why prostatic massage and irrigations into the bladder are necessary. The "cut-off" muscle which in a way closes the canal to the bladder at about six and one-half inches from the end of the penis, prevents any injected fluid that can be used with

* The American Physician, August, 1902.

safety by the patient from reaching the deep part of the canal, or posterior urethra, and if this portion be affected by the disease it can be readily seen of how little value will be injections that only reach the anterior portion. Irrigations that are forced gently into the bladder to be immediately voided by the patient, as is urine, thus flushing the entire canal, can only be given by the physician.

Prostate Gland

The prostate gland may be said to surround the urethra in its deep portion, near the bladder. If this organ be involved in gonorrhea the treatment indicated is massage by the physicians finger in the rectum, gentle in acute cases and with greater pressure in sub-acute and chronic processes. This massage it to be followed by irrigation into the bladder, not only for the effect upon the walls of the urethra, but also to remove the secretion of the prostate expressed by massage, which containing gonococci, may further infect the canal if not flushed out.

Sounds

The passage of sounds and deep instillations of nitrate of silver are useful for their tonic effect upon the mucous membrane of the urethra in catarrhal conditions that follow gonorrhea after the germs have disappeared.

The presence or absence of gonococci can only be determined by microscopic examination of the discharge from the urethra and the expressed secretion of the prostate gland.

Infection of the Innocent

It is these chronic conditions of the posterior urethra and prostate gland that so frequently lead to the infection of the innocent. A man contracts gonorrhea and after a variable time his discharge ceases; as far as he can then determine he is cured, though later on various symptoms may remind him of his "clap." Meanwhile he marries some clean woman and infects her with the gonococci which still thrive in his posterior urethra and prostate gland.

Gonorrhea contracted from a man in this condition rarely gives very active symptoms and the woman may have no idea of her condition. If she be of easy virtue, the infection is spread to others; and if a good wife she may bear a child with infected eyes (gonorrheal ophthalmia). When it is considered that this latter condition is responsible for over 33⅓ per cent of the blindness in the world, its gravity is realized.

It is probable that 75 per cent of the serious pelvic conditions in women can be traced to a gonorrheal infection from the husband who probably had no idea that the seeds of his past folly, lying dormant, (as is frequently the case) for years, would spring again into activity in his wife, frequently necessitating operations to be followed by sterility.

Right here it may be best to state that in treating gonorrhea, the all important point is the absolute cure of the disease and not the mere control of symptoms. The careful practitioner will examine, or have examined, microscopically the discharge in every case at frequent intervals, to be sure of the absence or presence of the gonococcus, and in the late stages of the other germs that occur in these discharges.

After the discharge has ceased the germs of the disease are usually present in the secretions of the prostate gland. This expressed by massage is examined at intervals until a number of specimens free from germs is obtained. The urine sediment, obtained with the centrifugal apparatus, is also to be examined for germs that may still be present in the urethral glands.

Time Required to Cure

As to the time necessary to cure a case of gonorrhea, no one can honestly make any positive statement. An uncomplicated case, involving only the anterior portion of the canal, can usually be cured in a "few weeks"; but when we remember that ninety per cent of all cases extend to the posterior portion of the canal, and that the prostate gland is involved in practically all posterior cases, it will be seen that the very rapid cures will be comparatively few in number. The posterior and prostatic cases will take usually several, and some, many months to cure.

Involvement of the small glands of the first part of the canal will also lengthen the course of the anterior cases. Either condition may be the cause of a persistent "morning drop."

Complications of Gonorrhea

Urethral Stricture

There are four varieties:

1. Spasmodic Stricture.—This is a symptom, and is due to an involuntary contraction of the compressor urethrae muscle, which in a way closes the bladder. This condition occurs in highly strung, nervous individuals and requires no lengthy description.

2. Traumatic Stricture.—Due to some injury to the tissues with resulting scar tissue.

3. True Organic Stricture.—Due to an inflammatory process, usually gonorrhea, and of sufficient severity to later produce scar tissue. This scar tissue gradually contracts and obstructs the flow of urine, producing in many cases retention that can only be relieved by the surgeon.

The important point to be remembered by all stricture patients is, that if they will see the surgeon once or twice each year, after their stricture has been thoroughly dilated, he can determine whether or not the stricture is again contracting and further dilation is necessary. Patients heeding this advice will rarely suffer from retention of urine or require operation.

4.—Congenital Stricture.—Like any congenital condition, the individual is born with it. It has no connection with gonorrhea.

Gonorrheal Ophthalmia

One of the gravest complications of the disease. Unless immediately recognized and actively treated, it may destroy the eye in twenty-four hours.

Swollen Testicle

A true gonorrheal orchitis or inflammation of the body of the testicle rarely occurs. The infection does extend to the epididymis or tail of the testicle. Epididymis produces great pain and discomfort, and confines the patient to his bed for a number of days or longer. Occurring on both sides, it frequently causes sterility.

Gonorrheal Rheumatism

This is the most painful and serious complication of the disease. It varies from slight pain in one or more joints (usually one at a time, thus the name non-articular Rheumatism), to such severe inflammatory conditions as to produce finally complete ankylosis (immobility) of the joint or joints involved.

Syphilis

This grave constitutional disease, regarded at one time as almost incurable, to-day gives most encouraging results when properly treated. It is most important that the patient should understand that his ultimate cure is mainly in his own hands, and that the treatment will extend over a period of many months after all appreciable symptoms of the disease have disappeared; during

which time he must be under the constant care of his physician, and absolutely faithful in following his instructions. The initial lesion, or first sign of syphilis, is a very innocent looking sore, appearing, if the disease be contracted during sexual intercourse, upon the penis. It may appear upon the lips or in the mouth if contracted by kissing or from some infected table utensil. It is seen occasionally in other parts of the body. It appears from three to five weeks after exposure; occasionally, not until six or seven weeks have elapsed.

This sore is termed a hard chancre, it usually feeling hard at the base if grasped with the fingers, in contradistinction to the soft chancre or chancroid which is purely a local ulcer, leading to no constitutional condition.

The chancroid, or local venereal ulcer, is due to infection from a similar sore, is a disease of the filthy, and probably caused by its own germ, the bacillus of *Duchré*. It bears no relation to syphilis except that the two infections may occur together, and for a time at least, confuse the diagnosis.

Diagnosis of Syphilis

This is made in acute cases with the aid of the microscope, by finding spirochetes in scrapings of the initial lesion or chancre; several weeks later by the Wassermann blood test.

In somewhat more advanced cases the presence of secondary symptoms will aid in the diagnosis. These are general enlargement of the lymphatic glands, most commonly noticed above the elbows and at the back of the neck; a syphilitic rash appearing upon the body and extremities, sore throat and mouth, and sometimes falling of the hair. The diagnosis of more advanced cases depends chiefly upon the history and the result of the Wassermann blood test.

Treatment of Syphilis

The principal drug used in the treatment of this disease has been, and probably always will be, mercury in some form. In addition salvarsan, or as properly known "606," now called arsphenamine in this country, is used where indicated. Potassium, or sodium iodide, is of great value in the relapsing form of the disease. Mercury is best given by deep injections into the muscles of the buttocks. It may be given in the form of inunctions (an ointment to be rubbed in). It should never be given by the mouth where either of the above methods can be employed. Internally it produces in most individuals so much gastro-intestinal irritation, with pain and diarrhoea, that it is doubtful if much of the drug is absorbed. The quantity finally absorbed must always be in doubt.

The individual having syphilis should never forget that if he follows his physician's advice as to treatment, etc., his chances of being cured are excellent. If he fails to follow this advice and stops all treatment when his symptoms disappear, his condition, perhaps years later, may be far more serious. Diseases of the bones, liver, stomach, throat, ears, arteries, spinal cord and brain are frequently due to syphilis. Paresis and locomotor ataxia are always caused by syphilis.

The Lesser Venereal Diseases Chancroid or Soft Chancre

A local sore appearing a few days after exposure, leading to no constitutional symptoms. Suppuration frequently occurs in one or more of the glands of the groins (suppurating bubo or "blue ball"). These latter frequently require incision and drainage, and heal very slowly.

Venereal Warts

Much like other warts except that they grow more rapidly. Usually removed with scissors or caustics.

Herpes Progenitalis

Numerous small blisters or open ulcers appearing on the prepuce or foreskin. Treated by cleanliness and mild antiseptics, and, if these fail, by circumcision.

Hygiene of Venereal Diseases

Gonorrhea

Diet.—Avoid foods giving rise to irritating compounds in the urine. These are asparagus, tomatoes, pickles, and all highly spiced foods; the condiments pepper, mustard, catsup, etc.

Drinks.—Avoid alcohol in any form; beer is particularly harmful. Also ginger ale, carbonated waters, tea, and coffee; claret and water may be taken with meals if desirable as a tonic, but even this it is better to eliminate.

Tobacco.—May be allowed in moderation.

Water.—The patient should drink as much plain water between meals as is possible without causing indigestion. His bowels should move freely every day.

Sexual intercourse and excitement should be avoided as they increase the circulation of blood in the affected parts, and thus add fuel to the flames.

Carrying the penis in a condom or "clap bag," or wearing cotton held in place by a long foreskin can only do harm, by increasing the general irritation and preventing the free escape of the discharge. An apron, consisting of an old handkerchief pinned inside the undershirt, is usually sufficient to protect the clothing. This should be changed frequently.

After handling the penis great care should be exercised to thoroughly cleanse the hands; they should be scrubbed if possible with soap and hot water. The discharge may be carried to the eyes on the patient's hands, and loss of vision frequently results from gonorrheal ophthalmia.

Care should be exercised on this same account that towels and vessels used by the patient are not used by others.

Rest is a great aid in the cure of gonorrhea. As little exercise as possible should be taken unless the general health of the patient demands it, when it should be very moderate. Riding the horse or bicycle, or dancing, cannot be allowed. The patient should bathe the genitals daily. There is no objection to the complete daily bath.

Syphilis

As soon as the possibility of syphilis is apparent, the patient should be warned of the danger of infecting others. He should kiss no one, and he should be particularly careful that his family or friends do not use drinking vessels, pipes, spoons or forks, after he has used them. The butts of his cigars and cigarettes should be so disposed of that the unfortunate vagrant may not be exposed to the infection they contain.

Toilet articles should not be used in common with other people, and the patient should shave himself.

The hands should be kept away from the mouth, as the sores occurring there are particularly infectious, and the saliva upon the hands may spread the contagion to others.

Avoid shaking hands when possible, particularly if there be any eruption upon the palms.

Sleep alone.

Marriage or extra marital intercourse should not be permitted for several years after the appearance of the initial lesion. The length of this period must be determined by the medical attendant in each case, and will depend upon the patient's general condition and the result of a number of Wassermann tests.

Cleanliness is most important. If possible, the patient should have a daily morning bath. This is particularly

(Concluded on page 285)

Team Play for the Benefit of the Patient

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SECRETARY, SECTION ON MEDICINE, ASSOCIATED OUT-PATIENT CLINICS

New York

General Foch, commander in chief of the Allied Armies, built up a tremendous offensive unit through combining all the forces of all the armies into one vast machine and at the same time preserving the autonomy of each respective army. He applied two principles that are essential in the successful consummation of any joint effort whether in war or peace—the combining of forces and the preserving of the integrity of the units.

The recent joint action of the Medical Society of the County of Kings and the Brooklyn Visiting Nurse Association in developing standing orders for the use of the nursing organization is an evidence of the practical application of these principles in community health work. While the standing orders are in themselves important, the real significance of this action is held in the mutual confidence engendered and in its auspicious potentialities.

The practice of medicine of a half century ago was very largely a one-man piece of work. The physician was not only the commander in chief of all the forces assembled for the patient's relief, but frequently he was lieutenant, corporal and private too. He had no one with whom to share his task; medical aids as we know them today, were unheard of. The practice of medicine today, with its emphasis on early diagnosis and prevention, is far more complex. The physician calls into participation the patient himself, the nurse, the pathologist, the social worker, the radiologist. The patient of today is not treated in terms of his disease but the disease is treated in terms of the patient, of the multitude of factors that influence it—home, family occupation, mental condition, health habits. Thus, the medical treatment of the individual today needs be based on teamwork, on calling into play the medical aids that have been devised to expedite and complete treatment, and the various agencies or agents concerned with his health.

As medical science has shown that through early diagnosis and preventive measures, illness can be prevented and health promoted, the entire philosophy of health work has changed from being on the defensive to assuming the offensive. This positive platform for health has brought a response from the layman that has registered itself not only in the cities of our country but in the furthestmost outposts. It is reflected in the popular demand for books, newspaper and magazine articles on health subjects, in the popular support of health projects, and in the individuals themselves as they go regularly to their family physicians for physical examinations. Furthermore it is reflected in the development and broadening of community health activities on a scale that has never before been reached.

Because of the multiplication of factors organized and developed to aid the doctor in the treatment of the patient, never before has there been greater need for teamwork on the part of all these factors.

No one health agent comes more frequently in contact with the physician in his work in the homes nor touches him so closely as the public health nurse. Going into the homes where the principles of hygiene must be practiced if they are to be effective in the community, teaching these principles through nursing care, through demonstrations and instructions, aiding him in his plan

of treatment, she is his indispensable ally. It is not her purpose to supplant the physician; rather it is her purpose to supplement and extend his work in the care of the patient through the skilled special services for which she is trained. The fundamental purpose of the physician and public health nurse is service to the patient. Each has a distinctive function not in any way overlapping that of the other, yet in common purpose they are integrated.

When physician and nurse do not get together in their joint efforts for the patient, the patient is the loser. When they do join forces not only does the patient profit immeasurably but their gain has been of mutual benefit, and the community has been strengthened. Cooperation is a sadly abused word. It does not mean "Sign on the dotted line if we are to work with you." It does not mean "so conduct yourself that we can work with you." Cooperation means teamwork and teamwork means exactly what the term implies—each part of the team pulling its share of the load.

The Brooklyn Visiting Nurse Association recognized this principle when it went to the Medical Society of the County of Kings for standing orders. Standing orders are designed for the protection of the patient—they enable the nurse to serve the patient in emergency or until the physician can be reached. They are of mutual interest both to physician and nurse. They need to be developed by physician and nurse. When the request of the Visiting Nurse Association was transmitted to the Medical Society, the Council of the Society, feeling that as the matter was a clinical problem which needed special consideration, appointed a special committee. This committee, after consulting with physicians regularly utilizing visiting nurse service, met with a committee from the Visiting Nurse Association and jointly these two committees prepared the standing orders for submission to the Medical Society. Not one of the least important by-products of this joint consideration was the cordial understanding of each other's functions and the mutual appreciation of objectives that was expressed by both sides. These two splendid organizations received an introduction to each other that not only breaks down isolation and clears away any misunderstanding, but that holds in it a promise of joint participation that will work to the advantage of the community, the patient, the physician and the nurse.

The special committee in recommending to the Society that the orders be approved, further recommended that copies of the orders be issued to every physician in the Borough of Brooklyn through the official channels of the Society. Twenty-six hundred physicians residing in this Borough have received the four-page leaflet carrying the standing orders together with a statement of the purpose and methods of work of the Visiting Nurse Association. This leaflet, bearing the seal of the Medical Society, is one of a series issued by the Society and is a feature of the comprehensive graduate education program of the Medical Society of the County of Kings.

The committee further recommended that joint participation and understanding between these two organizations be perpetuated through a permanent standing committee and the Public Health Committee of the Society was directed to include this in its activities.

As a further evidence of its cordial appreciation of the work of the Visiting Nurse Association the Society invited Miss Elizabeth Stringer, Superintendent, to appear before the Society at its monthly meeting to tell of the work of her Association, and to exhibit the film in which the daily round of work of the nurse is shown. The hearty burst of applause that greeted the picture of the assembled nursing staff testified to the excellent spirit that exists between the two organizations.

In providing for continued joint participation on problems that are of common interest to both physician and public health nurse a precedent has been established that will work only to the advantage of everyone concerned. In following the principle of combining forces, yet preserving the integrity of each agency, these organizations have recognized their interdependence.

The recognition of this interdependence is the basis on which all successful joint effort is established.

Unraveling the Cancer Knot

HARRISON TAYLOR CRONK, M.D.
New York

This paper is seventh in series, dealing with the cancer subject from an unusual angle. As reprints are not available, interested readers will find source of information only from copies of THE MEDICAL TIMES and these will be furnished as existent supply from back files permits.

The text ruling the writer's theses on the cancer subject holds to two main principles. These are that malignancy is caused by a specific germ presence (protozoic, not bacterial) working upon soil of special fertility peculiarly habituant to the degenerative years; and that remedial measure must attack this vampire presence by means strong enough to obliterate it; such means being a parasiticide of potency administered directly to the circulation in a form non-disturbing to physical comity but certain in its reachment.

The clinical result from application of advocated methods has been evidenced in response, characterized by diminution in size, and obliteration of growth, in a remarkable percentage of cases—all of which were of extreme, surgically inoperable variety; together with restoration of physical well-being as signified by increased hemoglobin (routing of cachectic advance) restoration of normal alkalinity, increase of appetite, gain in weight, and that return of normal vivacity which is not psychic but attendant only upon true activity of what was once called, the *Vis Medicatrix Naturae*.

The reader will observe from previous papers that the writer has made no claim to discovery of some new bacillary presence and a consequent achievement of serum-antitoxic effect in medication. He will likewise note there has been no talk of anti-bodies or their creation as result of medical administration. No new system of intravenous therapy or intramuscular injection is advocated. The medical routine is simply hypodermatic and as easily applicable in the homely practice of the ruralist as with the doctor who has metropolitan facility at his command.

This divergence is highly permissible, since it must be admitted that some of medicine's advances have been rather too far away from established medical convenience for the comfort as well as prowess of the old family doctor who fortunately exists along the highways the city doctor tours while asummering.

Nor in this medication, which is our part-subject, is there anything of a back-fire proposition which seeks by increased phagocytosis, induced by implantation of other aggravating disease elements, to promote attack upon a prefixed resident condition.

The allegation made, that cancer which so long has defied cure; defies it because our pathologists have exercised a too hide-bound devotion to bacteriology and its serums to exclusion of study in the domain of protozoology, contains much of truth.

This delinquency, however, is not an error of prejudice but one of custom. It is common enough to hear observation to effect that our higher medical, surgical and pathologic circles are not open to progressive doctrine and that the door of research or clinical oppor-

tunity is a closed one to he who ventures aside from the well marked road. This is only partly true.

Where such accused condition exists, reason is more usually found, either in gross divergence from the first principles of ethics or in egregiously unscientific premise of action. This last type of action appears to enjoy immunity however, if one may judge from recent reading of the not only tolerant but kind criticisms made concerning new discoveries by men in high place who must have smiled while issuing compliment.

* * * * *

The subdermal injective fluid which for purpose of brevity is called A-O and which is an isotonic combination of camphor, eucalyptol and creosote, has demonstrated characteristics which make it of high usefulness.

Added to simplicity of administration, it has been definitely demonstrated as result of thousands of injections that no physical reaction results. There has never been a needle abscess. It can be used with impunity in adult humans continuously in thirty minim daily doses over long periods.

Its self-sterilizing nature defeats fear of local lesion under avoidance of foreign introduction, and its satisfactory isotonic form causes it to effectually diffuse in the blood current with no discernibly attendant physical sign save recognition of characteristic taste in the mouth membranes a few seconds after injection.

We appear to have in A-O a type of medication which carried into other application may mean as much to therapy in general as it appears to mean to malignancy specifically. Aside from main subject it is gratifying to know we have at last so fully accomplished a method of applying such strong and effective medication as A-O contains, to delicate fluid tissues without slightest of resultant harm, yet with certain maximum of efficiency.

One of our leading New York pathologists lightly touched upon a delicate subject, incident to recent review of a lay book on cancer. He said "few elderly surgeons close their careers without expressing their long sub-conscious belief that there is a universal cancer parasite."

Was this written in sardonic vein out of superior theorem of wisdom, or was it result of that clear-sightedness which comes to all in later years after unsuccessful striving; the best of the utterance is its truth.

Surgeons, lacking in intense pathologic knowledge to be sure, but clear-visioned to their surgical failures, and much more clinically proficient than their brethren of the stool and eye-piece; are ceasing—more than some pathologists—to be dogmatic in their beliefs and practices.

Arising to new aim by profit of experience, they refuse to needlessly sacrifice life by hurried operation and wait upon what the doctor of medicine or the pathologist can

render to their aid. More than that, many of themselves are pursuing original research and perhaps we may say research of most intelligent sort, for we must not forget they are quite near the patient they serve.

What modern surgeon is there who includes the axillary tail in a complete mammary operation, who does not mentally question the removal of a natural fighting force? Soldiers fight to hold their outposts regardless of whether an enemy or two may get within.

What are metastases? Are they signs of victory or of defeat? At least they are signs of a good fight being put up. Very naturally the surgeon thinks of these things and becomes more and more averse to destruction of an ally he can conserve in his patient's interest.

Our effort in employment of such medication as A-O, being the fighting of disease inroad; and our channels being the circulatory channels of blood and lymph; it may be that the surgeon and old family doctor may soon shake hands at some axillary cross road.

Many interested correspondents (too many to give adequate reply to) have made compliment on originality of thought expressed in previous papers. While pleasing, that is not to best purpose.

Admittedly if there be sound reason back of these premises as to cancer's cause and cure, the best aid that can be rendered in an affair of such widespread moment to medicine, is intelligent criticism attacking fact whether primary or incidental. This need not be publicly. Whatever source of such criticism, my respect for the ethics that surround every circumstance—well vouched for by past observance—assures safety to the controversialist.

Whether I am correct in my belief that malignancy is due to a specific protozoon (*Trichomonas*) and even regardless of any protozoic cause, certain irrefutable fact remains.

That fact is, that on assumption of protozoic cause, as established by a line of scientific reasoning; devise-ment of a means to combat that cause, produces results which are beyond the domain of mental therapy and the good wishes of collaborators, and appears to be more governed by the laws of cause and effect than mere doctrinations of theory.

12 Fifth Ave.

Neuro-Syphilis

(Concluded from page 266)

A blood Wassermann and a lumbar puncture is performed also on these cases for diagnostic purposes.

It is not possible to treat this group in an intensive manner. Many are below par and their general condition must be greatly improved before and specific treatment can be tolerated. Older people do not as a rule tolerate the arsphenamines well. If it is used, it is in small weekly doses and in those who have a robust constitution. It is in this class that mercury rubs and potassium iodide in increasing doses is indicated. No spinal treatments are given to patients above fifty-five years of age.

The colloidal gold, spinal and blood Wassermann tests remain unchanged.

Two intensive therapy in patients with weakened tissues breaks down the defensive forces and violent reactions occur; urinary and rectal troubles may develop, anesthesia and paraplegia may follow.

In the second and third group we have treated 337 cases over a five year period. Of this number 90 are home or 26 per cent. One hundred and five are at the hospital at 31 per cent.

At the present time there are 195 patients of this group living and accounted for, a total of 57 per cent.

During this five-year period 97 patients have died from the results of syphilis or 28 per cent.

Fourteen patients died, causes as follows:

- 2—shock following a fracture.
- 3—following operations.
- 3—tuberculosis.
- 1—suicide.
- 3—pneumonia.
- 1—typhoid.
- 1—chronic nephritis with mitral insufficiency.

Included in this total number of cases are 23 who had no treatment and died in a few days after entering the hospital.

Eight went home and did not continue to take treatment.

In the 105 cases in the hospital only three are in bed. The remainder are able to do various duties and many have privileges of the grounds.

Twenty of the 105 cases in the hospital are in their fifth year.

Twenty-three of the number at home were admitted to the hospital over four years ago.

My experience with tryparsamide is too limited at present to make any statement.

Sulpharsphenamine was employed on twenty-six patients. At some period during the first course jaundice developed in six cases. It is needless to say we do not use that preparation any longer.

Conclusions

I. The number of neuro-syphilitic cases has increased. Two reasons for this condition are:

- (a) The improvement in our diagnostic ability to recognize neuro-syphilis early.
- (b) The insufficient treatment of the primary and early secondary stage with arsphenamine.

Three classifications are made:

- I. The ambulatory or office patient.
- II. The cerebro-spinal type.
- III. Paresis—acute and chronic.

In the first group intra-spinal treatment is not indicated.

In the second group a combination of intra-spinal and intravenous treatment is necessary.

In the acute type of the third group pooled arsphenaminized fortified serum is given the day following the first intravenous treatment as it has a marked effect on quieting the excited condition of the patient.

One course of treatment with a negative Wassermann means little. Every syphilitic patient should have a lumbar puncture performed.

The treatment of syphilis is the prevention of neuro-syphilis.

Sunlight as a Health Factor

G. W. Bailey writing in *Prevention*, a bulletin of the New Brunswick, Canada, Department of Health draws attention to the influence of sunlight as a factor in good health. Its potent power is seen in the prevention of rickets by sunlight and cod liver oil, the cure of tuberculosis of peritoneum, as well as lungs by admission of light and fresh air. The healing ray of sunlight is probably the ultra-violet or some other chemical ray. Children sitting all day in school should have abundance of sunlight, as it makes for good spirits as well as health, yet he was sorry to say two of the larger schools of his district have grave faults in this respect. In one ten room school the primary grades have windows facing west and the children leave before the sun gets around to the west. Artificial illumination by electric light has to supplement the daylight, especially when days are short and no snow on ground. Another large school has nearly every room with windows due north and no admittance of sunlight.

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NEW YORK, DECEMBER, 1924

The Yearly Index

A comprehensive and convenient index to the MEDICAL TIMES for 1924 is now being compiled. To subscribers and advertisers desiring to procure the same, we shall be glad to send a copy of the Index on request. But, as we shall print only enough to supply the estimated demand, all who wish a copy are urged to send for it at once.

Mind and Medicine

In his searching little book, Dr. Thomas W. Salmon, Professor of Psychiatry at Columbia University, adequately accounts for the inception and growth of the jazz cults. He places the blame squarely where it belongs, upon the shoulders of that majority wing of the medical profession which has, until recently, refused to regard abnormal mental phenomena as facts in the same way that it regards hemorrhage and fever as facts.

The more physical of biologic phenomena have engrossed the attention of our ultra-scientists. It has not been fully realized that fear demoralizes and kills people just as surely as carcinoma.

The average medical man knows the names of rare tropical diseases better than he knows those of the commoner types of insanity.

The general hospital of the future will have wards for the mentally ill as well as for the physically ill.

The medical school of the future will study man in his totality. And this will not mean merely the inclusion of a few lectures on mental diseases.

The physician of the future will confront the quack with an equipment going far beyond the latter's meager and merely intuitive or instinctive understanding of the psychoneurotics who now constitute the manna which nourishes him.

Even when confronted by abnormal mental phenomena in the course of physical diseases we have stupidly ignored or slighted them, which is as bad as if we ignored or slighted blood chemistry. Claiming to practise an art, we have acted as ignorantly as would a painter who steadfastly refused to use one of the principal pigments.

As Dr. James J. Walsh puts it, it may be of far greater moment to know what kind of a patient has the disease as what kind of a disease has attacked the patient.

The mental phenomena of our medical and surgical patients should challenge our attention quite as much as their physical signs.

Dr. Salmon believes that with this type of prophylaxis in operation the isolated insane will dwindle greatly in numbers.

Our opportunity is great and immediately at hand, since some authorities estimate that about half of our office patients present psychoneuroses either as the whole or as part of their troubles.

A word of warning is in order at this point. It would not surprise us if the reaction, when it attains full strength, should swing us too far away from rational scientific moorings for a time. This reaction seems bound to come upon us, particularly as the function of the practitioner of the future will pertain more to disease prevention than to therapy.

A good primer of the new psychology, by David Seabury, is about to issue from the press of Boni and Liveright. Its title will probably be "Unmasking the Mind." Harvey O'Higgins' book on "The American Mind in Action" is another enlightening contribution. "The Re-Creating of the Individual" (Hinkle) is a valuable work. Of course, William A. White's "An Introduction to the Study of the Mind" takes first rank in this class of literature.

From Under the Southern Cross

The recent Clinical Congress of the American College of Surgeons was especially graced by the presence of three gentlemen from the other side of the world, Dr. James Sands Elliott, of New Zealand, Dr. N. D. Royle, of Australia, and Dr. John I. Hunter, also of Australia.

The first named of these gentlemen had much to tell of the radical steps taken by his Government looking toward the health of the people. In New Zealand the teeth of all the school children are cared for by young women specially trained for this purpose, and this care includes the filling of cavities; these young women are not graduates in dentistry, be it understood. Irregular practitioners simply cannot practise in New Zealand; if any ever appeared, they would speedily be chased into the Pacific. Old-age pensions are being increasing extended. Legislative sanction will shortly be given to the sterilization of all highly defective persons. Motherhood is revered, families are large, and highly successful efforts, on a nation-wide scale, to insure breast-nursing, are made by an organization known as the Plunkett Society, the women members of which are valiant crusaders in this cause, enjoying the greatest prestige in the nation and wielding the strongest political power. The Governmental ministry of health possesses powers that are practically despotic, and uses them strongly and wisely. New Zealand is an Anglo-Saxon community which, under difficult natural conditions, determined to survive and to

achieve great things. She has survived and she has achieved. The story, as told very charmingly by Dr. Elliott, sounds like a realized Utopia of things medical. And we daresay that these progressive people would be sadly puzzled by our understanding of radicalism, and by the political counterfeits who masquerade in its guise in this country.

Dr. Royle is a surgeon who has devised a daring and promising operation upon the cervical and abdominal sympathetic for the relief of spastic paralysis of various types. His work is grounded upon the soundest physiological principles, worked out with the utmost thoroughness by his colleague, Dr. Hunter. During the fascinating expositions of these gifted young men we could not help noticing that their exhaustive presentation of the physiological aspect of their work seemed to bore the audience, and we wondered whether this betrayal of impatience did not reveal the weak spot of our own surgery—failure to base our work always upon well understood and laboriously worked out physiological principles.

A Serious Problem

Middle-class people who are obliged to enter a hospital nowadays spend so much money for board, nursing and other bills that there is little or nothing left for the doctor, whether he be a member of the staff or the family physician.

So much is this the case that there is said to be an increase in home care, even involving operative work of a sort which we have grown accustomed to associate with the hospital. It is a self-defensive gesture on the part of both patient and doctor.

Of course, two things militate against any great growth of this practice. First, many people no longer live in "homes," in the old-fashioned sense of the term, being now housed more like rats than human beings; and second, competition is still keen among the members of a hospital staff to roll up the best record of private patients sent in to the services.

The entire situation is one more evidence of the present economic pressure on the middle class, including the physicians themselves.

It is a very serious problem. Of course, there is nothing new in the spectacle of the physician acting as though he were above the operation of economic laws. We are merely registering the fact that the pressure is growing considerably greater and that the maintenance of his dignity and even of his existence is becoming more and more a precarious thing.

The middle class seems to be in for still harder hitting at every vulnerable point.

What the ultimate outcome will be is not hard to conjecture.

Denmark is very, very rotten.

The American College of Surgeons

The recent Clinical Congress, held in this city, was a great success, due to the admirable plans of Dr. Eugene H. Pool and his Reception Committee. The hospitals in New York and Brooklyn presented interesting programs to the visiting Fellows and guests who must have been convinced that is or will be, the greatest medical center in the world. 83 out of the 115 hospitals were classified as being "standardized" according to the requirements of the college, and a stimulus was given to the other institutions which did not meet the minimum requirements to attain them in the near future. The meet-

ings for discussions were unusually interesting, the symposium on cancer especially, and the presence of an unusually large number of foreign surgeons added to their value.

The addresses were of a high order of excellence, especially those of the new President, Dr. Charles H. Mayo, and that of Dr. Chipman of Canada. It was delightful to hear the phrase "We Americans" so often on his lips and to feel that the College has really become Pan-American. The convocation was impressive, as never six hundred new Fellows were received, literally from all parts of the world, and the list of Honorary Fellows had notable additions.

The history of the College (now numbering over six thousand active Fellows) was sketched by Dr. Chipman and his lofty idealism must have stimulated his youthful hearers like the blast of a trumpet. Certainly any man who listened to his words and those of the President must have gone out with fresh allegiance to the oath of the College and, if he had offended in the past, with a resolve to "go and sin no more." The fitting tribute was paid to Dr. Franklin Martin, the Director-General, to whose untiring energy and administrative talent the College owes its existence and growing prosperity. May he preserve his youthful vigor for many years to come, until his sturdy child has grown to full manhood.

H. C. C.

Miscellany

Conducted by ARTHUR C. JACOBSON, M.D.

161 COLUMBIA HEIGHTS,
BROOKLYN, N. Y., October 10, 1924.

Arthur C. Jacobson, M.D.,
THE MEDICAL TIMES,
95 Nassau Street, New York.

Dear Sir:

Do you wonder why the layman is losing faith in the sacrosanct shamans of your trade? Witness the quotation from the *New York Times* re Dr. Albert Abrams! Are you really hopelessly stupid or simply malicious? The former is worse than the latter, you know. (I refer to this month's issue of your *MEDICAL TIMES*.) Your ignorance does not excuse you. If you want to know just how stupid (or malicious) you and the *New York Times* are, come to a layman who is sufficiently alive from the ears up and learn something about the theories and clinical results of Abrams' discoveries. That is, if you are intelligent enough to want to know something of real benefit to mankind—something out of the prescribed hokum of the A. M. A. I am at your service any time.

JOSEPH KOVEN.

Mr. Koven's reaction to the quotation in question is very interesting, and suggestive. We published the quotation and its caption without any comments and behold the resulting snappings and frothings. The question arises, does an intensive course of the Abrams' method change sunny natures into snarling ones? This untoward result of the system has apparently not been taken into account by its adherents. It seems to us to be a serious sequela, one indeed that would alone condemn the system no matter how beneficent its other effects might be. What is the use of employing a technic that cures one's tuberculosis or cancer but leaves one in the state of mind revealed by Mr. Koven?

Of course, this is all assuming that before Mr. Koven subjected his precious carcass to the electronic currents he was a gentle, kindly and cheerful person. Could the man who wrote the foregoing letter ever have been such an individual? Is it possible? We give him the benefit of the doubt and believe that he was, and that the sad damage now observable in him was effected by the elec-

tronic system. If there were some way of de-electronizing such an individual we should strongly favor its application, even at the cost of a return of the disease of which he was cured, with fatal results. Any one foolish enough to submit himself to the electronic method deserves punishment of a severe sort. On second thought, however, it is perhaps as well to let Mr. Koven remain in his present state, as a terrible warning to others.

A. C. J.

Needed in Self-Defense

In the general muddle in which the whole world has been engulfed for the past ten years, medicine has not escaped. The ultra-scientific spirit of the times has brought about a severe professional "indigestion." We are unable to digest all the half-baked pabulum prepared for us by the laboratory conspirators. And very much of this material is discarded very soon after its creation.

What are the remedies?

A moratorium of at least five years should be declared, during which time we could clean and rearrange our medical household. Then a medico-legal body having juridical powers should be set up, to which practitioners, either individually or in groups, could apply for writs restraining laboratory workers from "glutting the market" at any time with their wares, or even from prosecuting unpromising researches. They should be required to show cause, upon regular and proper demand, why they should not desist from harassing a profession unable, through no intrinsic fault, to absorb or apply their never-ending and for the most part useless contributions.

Pyloric Obstruction

(Concluded from page 271)

Einhorn¹ has demonstrated the usefulness of the duodenal feedings in selected cases of peptic ulcer. Therefore I passed the Einhorn duodenal tube on this patient with the idea of treating him by duodenal alimentation, as the findings indicated that this was an ideal one for medical treatment. The bead of this duodenal tube measures $\frac{5}{8}$ of an inch in length and $\frac{1}{4}$ of an inch at its widest point.

In spite of the liberal use of antispasmodics, the duodenal tube did not pass the pylorus in four days. (Fig. 2.) Our experience has been that when a duodenal tube does not reach the duodenum in these cases within four days, we are dealing with a case of pyloric obstruction in nine out of ten cases. The occlusion does not necessarily have to be a complete closure.

I treated this patient medically for a while because he refused to be operated upon. Finally he consented to surgical intervention and he was operated upon by Dr. John Linder at the Brooklyn Jewish Hospital on February 11, 1924. I was present at the operation. Dr. Linder did the latter mostly under local anaesthesia which was supplemented by gas and oxygen.

At the operation free serous fluid was found in the peritoneal cavity. The gall bladder and stomach were negative. The first portion of the duodenum was almost completely encircled by a large callous craterlike ulcer about one inch wide which encroached on the lumen. The pylorus was partially patent. We can readily understand that the lumen was not completely obliterated because the barium did not remain in the stomach at the end of six hours. Dr. Linder performed a posterior gastro-enterotomy and occluded the entire pylorus. The man made an excellent recovery and left the hospital in twelve days.

The importance of this case is that the x-ray showed no gastric residue at the end of six hours. From the radiographic findings one would be justified in stating that we were dealing with a duodenal ulcer with a patent pylorus. Furthermore this case appeared to be an ideal one for medical treatment. In the majority of cases of peptic ulcer a patent pylorus

is a contra indication to surgical intervention. While this is not true in every case it holds good for most of the cases. Whereas in pyloric obstruction surgery produces marvellous results. So it is quite important to decide whether the pylorus is occluded or not in peptic ulcer.

In the case that I just described there was a small opening to allow the barium to go through. But if the bead of a duodenal tube did not go through in four days it was certain that we were dealing with a pyloric obstruction for all practical purposes. If the bead did not pass through the pylorus then surely enough food to sustain a patient's life would never go through. The man lost about 30 pounds in a comparatively short time which indicated that sufficient food did not enter the duodenum. Therefore, an operation was indicated in this case and it proved very successful as surgery usually does in these cases.

I would, therefore, urge the more frequent use of the duodenal tube as a diagnostic measure in the routine examination of gastric cases.

¹ Max Einhorn: "Diseases of the Stomach." Wm. Wood & Co.

77 East 79th St., N. Y.

Suggestions for Venereal Patients

(Concluded from page 279)

desirable if the treatment consists of the rubbing in of mercurial ointment at bed-time, as it keeps the skin more active and better able to absorb the remedy.

The teeth should be well cared for both by the patient and his dentist. The latter should be told that his patient has syphilis. He will regard this as a professional secret, and it is necessary for the protection of his other patients, as all dentists do not as yet boil their instruments (as they should) after treating each patient.

The physician will prescribe mouth washes and gargles for the various ulcerations that occur in the mouth and throat.

The patient should lead a well ordered, regular life, avoiding undue fatigue but still taking a fair amount of outdoor exercise.

Diet.—The diet should consist of plain unstimulating food and absolutely no alcohol, except as in gonorrhea, a moderate amount of diluted claret, if it be indicated for its tonic effect.

Smoking may be allowed in moderation, except when there are sores in the mouth or throat, when it should be totally interdicted.

Prevention of Venereal Diseases

There is only one way to avoid these diseases, i. e., abstaining from illicit intercourse.

Those constantly exposing themselves may sometimes escape infection by the following precautions:

Avoid women with skin eruptions, enlarged glands of the groins, or other evidences of disease.

After exposure, urinate at once, holding the end of the penis tightly several times and ballooning the urethra with the urine before allowing it to escape.

Wash thoroughly with soap and hot water. The use of a five per cent argyrol injection to be held in the canal of the penis for five minutes as a prophylactic against gonorrhea, and the thorough rubbing into the head and skin of the penis of an ointment of 60 per cent calomel as a prophylactic against syphilis, have been of great value. This method greatly reduced the number of venereal cases in the army during and previous to the World War.

105 East 19th Street.

Acquired Characters

(Concluded from page 276)

Mr. Reich used nightingales as teachers for his canaries, and finally got canaries which would sing the nightingale song without direct instruction. That is, by practice, his birds developed their vocal organs along the nightingale line until the nightingale song became the natural song. If Reich had attempted to make nightingale singers out of canaries by selection, and without using nightingale tutors, he would have had a long and difficult job. If, instead of using canaries, he had begun with songless birds and attempted to produce the full and complete nightingale song in such birds and without instruction, he would have had something comparable to the idea that animals can be made immune to some particular disease by the selective death rate.

It is a general principle that when a disease strikes a community for the first time, it is much more deadly than it is afterwards. Also, that immunity against a particular disease is developed only in communities in which the disease is continually present. The first of these is explainable on the assumed selective death rate, but not so the second. Killing a non-resistant individual does not add anything to the resistance of some other person, and immunity results only when small resistance is developed into great resistance.

Reich could not have made nightingale singers out of his canaries without the use of nightingale teachers, but the nightingale teaching did not implant the nightingale song in the canaries. It simply furnished something for the canaries to imitate, and in imitating they developed their powers along a new line. Immunity to a particular disease cannot be produced in the absence of that disease, but the presence of the disease does not produce its own immunity. It produces a condition which the organism must combat in self defense, and in combatting that disease it develops powers specific to that disease.

The fact that a canary can sing the canary song does not mean that he can sing the song specific to the nightingale, but the fact that he can sing the canary song makes it easier for him to learn the nightingale song than if he could not sing at all. Going a step further, if a human being has learned to sing a dozen songs well, it is easier for him to learn another song than it would be if he had never learned to sing at all. In a case of this kind, it is not the songs remembered which help him to learn an entirely different one. It is the development of the power of learning by the exercise of learning.

While being immune to some particular disease does not give immunity to some other disease, still if a person has become immune to a variety of diseases, by vaccination or otherwise, it is easier for him to develop resistance to some other disease than if he had not developed resistance to any disease. There are several kinds of vaccination now in use, and it is probable that many more will be developed. If a man should be vaccinated against a dozen diseases, he will have considerable capacity of resisting entirely different diseases. In fact, by following along this line it is probable that the race can be made immune to practically all diseases, or so highly resistant that diseases will not be dangerous.

Monadnock Block.

The Physician's Library

How to Keep Well or The Preservation of Health and the Recognition of Disease. By Andrew L. Currier, A.B., M.D. Cloth, 782 pages. New York: The Century Co., 1924.

This attractive book, written for the laity, as the author modestly states in The "Foreword," has been favorably noticed in many papers and magazines and deserves recognition from a strictly medical standpoint. Suffice it to say that it is written by a physician of forty years' experience, once a specialist in gynecology, who has matched the wonderful progress of medicine and surgery during four decades, so that his comments on when taken excathera. Medical authors too often lose sight of the fact that they should write, not alone for members of their own profession, but for the public at large, because sooner or later all the most recent fads and fancies in medicine, which have flattered and faded, reach the laity through sensational articles in the press and popular magazines, distorted and inaccurate. How much better to then set forth sensibly and conscientiously in this unpretentious book!

If the medical reader will take the trouble to look through the chapter in hygiene, cancer, endocrines and disease of women, and note the author's sensible advice to his lay readers, he must admit that this work is a distinct improvement in the popular "Household Medicine" of forbears. To our mind it has its plan, just as much as the latest monograph in abdominal surgery, or the ductless glands. As such we welcome it.

H. C. C.

The Inheritance of Acquired Characteristics. By Dr. Paul Kammerer of the University of Vienna. Translated by A. Paul Maerker-Branden. 414 pages, New York: Boni and Liveright, 1924.

One scientist has said that Kammerer began where Darwin left off. At all events he has gone much further into some of the biological problems than any other writer. He has demonstrated that only do people inherit characteristics from their parents, but from their ancestors in past generations, and he believes that very few of our appealing characteristics have been acquired during our own life time.

The book is intensely interesting and is worthy of the consideration of any serious minded person.

Life Insurance Examination. Edited by Frank W. Foxworthy, M. D., Indianapolis. 738 pages. St. Louis: C. V. Mosby, 1924.

This is a collaboration representing the ideas of fifty of our best known life insurance medical directors and examiners.

The entire subject is most thoroughly covered. Not only do the authors take up the function of the examiner, the referee and the director, after explaining various types of insurance, but they go into the etiquette of examinations and consider the various diseases and conditions which one is likely to find.

This book is bound to prove of distinctive value to the physician making life insurance examinations.

Modern Methods of Treatment. By Logan Clendening, M.D. of the University of Kansas: 692 pages. St. Louis: C. V. Mosby Co., 1924.

Believing that the average text book is either badly balanced, includes too much or too little, or does not represent modern thought, the author has written a book which he feels obviates these disadvantages.

In its preparation he has been assisted by six physicians who presented chapters on special topics.

It would be a little difficult to say that the author had not stumbled over some of the obstructions which some other writers have encountered. On the other hand, he has presented a carefully considered, well written book which will prove of real value to the reader. It is neither abstruse nor prolix and contains the points necessary to inform the seeker of knowledge.

International Clinics. Vols. I and III. 34th series, 1924. Philadelphia & London: J. B. Lippincott, 1924.

These volumes contain the usual number of interesting and instructive articles. Vol. I is devoted to three clinical lectures, a symposium on the new-born, with a series of articles devoted to a diagnosis and treatment, rectal diseases and industrial medicine. Not the least valuable of the contents are Dr. Sweet's Mutter Lecture of the College of Physicians of Philadelphia, and Dr. Cattell's Progress in Medicine for 1923.

In volume III the subjects are Public Health and Hygiene, Diagnosis and Treatment, Medicine, Pediatrics and Surgery.

Goitre. By Israel Bram, M.D. of Jefferson Medical College. 479 pages. New York: Macmillan Company, 1924.

This is a serious discussion on the non-surgical types of goitre with treatment. Believing that goitre is preventable, that early goitres are curable, that thyroidectomy is a failure in many cases, the author presents a book for the purpose of determining that many of the goitres treated surgically can be treated non-surgically with success. He observes that thyroid enlargements come under two heads, surgical and non-surgical and devotes his efforts entirely to the latter type. Through proper and early diagnosis, hygiene, diet, local and medicinal measures, psychotherapy and the like, the author is able to show that goitre can be successfully handled in many instances through non-surgical means. He has brought to the reader's attention through a series of excellent pictures, the tangible results of his treatment, and his case reports are elaborate and conclusive.

The bibliography is rather extensive and all in all Bram has stated his case and proved it to the average man's satisfaction.

Public Health

Eyesight in Motor Car Workers

Over half the workers in the United States engaged in building our motor cars lack normal vision, investigations by the Eye Sight Conservation Council of America reveal. Similar conditions, it is asserted, exist among millions employed in other enterprises.

Tests carried out by the Buick Motor Company at its plant in Flint, Mich., in co-operation with the Council, show, as reported by R. F. Thalner, the Safety Director of the Personal Service Department of the company, that 56 per cent of the company's new employees have defective eyesight, the eyes of all having been examined when application for employment was made.

Working with the Council in its nationwide campaign of eye conservation, the Buick Company is testing the eyesight of each applicant for work, the results being recorded daily on the personal record cards of employees, who at this time total 24,451.

The situation at the Buick plant, following similar revelations at the Ford works in Detroit, and at other large industrial establishments, provide ample evidence that neglect by industry of the eyes of workers continues widespread, according to the Council, which, in its report, just issued, says:

"The results of eyesight tests of the 3,513 applicants for employment with the Buick Company may be considered as a representative standard of measurement not only for the entire automobile industry but for the millions of persons engaged in other industrial pursuits in the United States. The persons examined at the Flint plant came from many different types of occupations seeking employment in the great variety of jobs to be had in a large plant manufacturing a highly complicated product."

The complete figures on the Buick Company's tests for four months show that only 194 or 5.5 per cent of this group of 3,513 had their vision corrected while 1,970 or 56.1 per cent were in need of correction. During the first month eye tests were made of 1,566 applicants for employment which revealed 56.8 per cent with defective vision. Of 892 applicants during the second month, the defective percentage was 56.9; of 188 during the third month, the percentage was 55.3, and of 767 during the fourth month, it was 54. The average for the four months disclosed that 56.1 per cent of the 3,513 applicants had poor eyesight.

"The proportion of defective vision found by the Buick Company," the Council's report declares, "closely approximates that generally found among any group of workers, when similar tests are made. This proportion is based upon the results of very simple tests. More careful examinations of other large groups of employees of both industrial plants and commercial establishments show that fully sixty-six per cent have defective eyes."

"At the time of application for employment it is not practical to take the time to make thorough eye examinations. Superficial acuity of vision tests serve the employment manager a very useful purpose, for they point out the applicants most seriously handicapped. After these men are employed the records of the preliminary tests indicate the individuals most urgently in need of a further complete test."

"New employees of the Buick Company who have eye defects of a sufficient degree to handicap them are assisted in having their defective vision corrected. The company is looking after the eyes of its employees in other ways also. The Safety Department is carrying on a well or-

ganized accident prevention campaign. Definite regulations governing eye protection are embodied in safety rules which apply to the wearing of goggles. The management supplies goggles to workers occupying jobs which afford the slightest likelihood of eye injury."

"The number of eye accidents has been greatly reduced since 1921, when the goggle campaign was started. In 1920, thirteen persons were blinded in one eye; this number had been steadily reduced to five in 1921; to three in 1922, and to three in 1923. Provision is now made for placing in non-hazardous jobs those disabled through eye injuries."

Lighting is an essential factor of the Buick system of conservation, ninety-five per cent of the work in the plant being done by artificial illumination. Measurements are made in the various departments to determine whether the proper amount and distribution of light is provided.

Elaborate provision is made for the maintenance of the lighting system. Painting the ceilings and the upper part of the side walls white is an effective aid. These and kindred devices contribute vitally to the end sought.

The result of this system of prevention, it is said in the report of the Council, is increased production, "due to many incidental factors such as fewer accidents, less waste and spoilage of material, improved quality of workmanship and greater individual comfort and efficiency."

The statement of the Buick Company upon which these facts are based is one of the many similar statements made to the Eye Sight Conservation Council by large industrial concerns in all parts of the United States, representing practically every important class of industry, and employing more than 1,000,000 men and women. The summary of these data, it is said, embodies the most comprehensive compilation of industrial eyesight statistics ever undertaken.

"The records," the Eye Sight Conservation Council's report discloses, "cover the examination of the eyes of 204,817 employees. It is regrettable that there are not more than 100 or 150 companies in the United States employing upwards of 1,000 persons which consider it essential to test the eyes of applicants for employment. Still fewer companies carry on this activity periodically for permanent employees."

The Council recently completed a national survey of conditions affecting the eyesight of industrial workers and school children, the findings being embodied in a report now being prepared for publication.

"The completion of this undertaking," the Council's report concludes, "has been made possible by the splendid co-operation of the many industrial executives, school authorities and state officials who have generously supplied information and who have in this way given assistance in promoting a wider knowledge of the importance of eye hygiene and care of the eyes."

Loss by Defective Eyesight

Defective eyesight in the public schools is costing the taxpayers of the nation at least \$130,000,000 annually, it is asserted by the Eye Sight Conservation Council of America, which, in a statement sent to directors of summer schools throughout the country, urges organized conservation of vision as a social and economic need.

The Council points out that poor eyesight is responsible for much of the retardation in schools, and makes public the results of investigations showing that a large proportion of backward children have visual defects.

Accompanying the statement is a report revealing that heavy moral and financial losses arise from this evil. Approximately 25 per cent of all school children in the United States, the Council finds, are retarded in their studies and fully one-third of this retardation is conservatively estimated as due to defective vision.

If this is a correct estimate, there are at least 2,000,000 school children in the United States one or more years behind in their studies because of defective vision, says the Council's report, continuing:

"According to the United States Bureau of Education the cost of public elementary and secondary education for the entire United States averaged in 1920, \$64.16 per pupil per year. If each one of the 6,000,000 retarded children in the United States, as estimated, was forced to drop back only one year, the cost would be \$390,000,000."

"The public school system spends this amount each year in order that these children may have one or more years longer to complete their education. At least one-third of this amount or \$13,000,000 is lost annually because the eyesight of the children is neglected."

"This estimated cost is low, for the average backward pupil is retarded more than one year. Studies made in two

cities of 5815 retarded pupils show a total of 12,970 school years lost, making an average much in excess of two years for each retarded pupil.

"Furthermore, the estimate does not represent the total loss to the child and to the state when consideration is given to the future inefficiency, lowered earning power and less competent service of the individual as an economic unit of society."

John J. Tigert, United States Commissioner of Education and a member of the Board of Councillors of the Eye Sight Conservation Council, is quoted as asserting, after a careful review of the situation, that "one of the greatest disturbing factors in measuring the effects of defective vision upon retardation is the fact that faulty eyesight invariably leads to other troubles and the effect of these is not attributed to defective vision."

The Council's statement to summer school directors, signed by Guy A. Henry of New York, General-Director, says that "a large percentage of the pupils attending summer schools are obliged to do so merely because they have not kept up with their classes; no doubt a number have been retarded in their studies due to defective vision."

In the report disclosing waste the relation between sound vision and school progress is indicated "Defective vision is responsible for much of the retardation in school progress which exists in the educational institutions of the country," says the report.

"Investigations of 28,667 public school children with defective vision show that of this group an average of 67 per cent were retarded in their studies one or more years. This is almost three times as high as the retardation of groups when not classified according to eye sight. In another group of 32,050 pupils of which retardation investigations were made without segregating or giving consideration to condition of eyes, the proportion of those retarded in their studies averaged 24 per cent."

Of 7,319 school children found with defective vision in the public school clinic of one of our large cities, 72 per cent were backward in their studies. An examination of 2185 rural school children in a mid-western state disclosed that of those retarded nearly 60 per cent had visual defects, according to the Council.

"The correction of visual defects results in a marked improvement in school progress," the report continues. The records of 20,000 cases sent to a public school eye clinic for correction of refractive errors show that from 60 to 70 per cent of the children were classified as backward, mentally deficient, stupid or habitually left back. The careful follow-up system proved that after their defective vision had been corrected, 70 to 80 per cent of these children progressed and took their place in the class with the normal average child. The reason the remaining 20 to 30 per cent did not progress was because their retardation was due to causes other than defective vision.

"The proportion of retardation in another group, all with visual defects, was found to be 85.4 per cent. One year later, after the defective eyes had been corrected by glasses, only 17 per cent of those corrected continued to be backward in their studies.

"Furthermore it has been found that the proportion of retardation increases with an increase in the degree of visual defect. Pupils who have less than one-half normal vision are much more retarded than those with lowered vision of a lesser degree."

Diagnosis and Treatment

Arsenical Pigmentation of the Mouth and Skin

Stockman believes that during the prolonged treatment with arsenic of cases of chorea, pernicious anemia, lymphadenoma, psoriasis, and other chronic disease, pigmentation of the skin and keratosis are not infrequently produced, but their occurrence must be considered as relatively very rare in proportion to the large number of cases which are so treated without any untoward effects.

It is notorious that arsenic causes these and other pathological lesions much more rapidly and after a much smaller quantity in some persons than in others. Thus pigmentation, keratosis, and neuritis may appear in a few weeks or months, all together or singly, or may not appear at all even after years of arsenic administration. The reason of this variation in action is unknown, and for the present it has to be put down to individual differences or idiosyncrasy.

The skin coloration fades with very varying rapidity, sometimes in a few weeks, sometimes only after months, or in two or three years, and Cheadle has recorded an instance of its being present after nine years and presumably permanently. In his (Stockman's) experience it almost invariably disappears fairly rapidly, and has no deleterious influence on the general health. This is also true of keratosis, although it also may be very persistent, and arsenic cancer may result from prolonged irritation of the skin by the drug. On the other hand neuritis, which is equally capricious in its incidence, is very tedious and difficult to cure, and its possible occurrence should always be carefully watched for and avoided. It may prove permanent and even fatal in extreme cases.

It is difficult to determine exactly when or by whom pigmentation of the skin was first noticed as a result of the therapeutic administration of arsenic. Arsenous acid, realgar, and orpiment have been used continuously from the earliest medical times, and their acute poisonous effects have long been familiar, but knowledge regarding the symptoms of chronic poisoning has dawned much more slowly.

Arsenical paralysis is said to have been first recorded in the thirteenth century, and at infrequent intervals afterwards till 1857, when it was more particularly described by Leroy, and since then by very many others. In the eighteenth century, when various preparation of arsenic were widely and successfully used in the treatment of ague, it was known that they might give rise to paralysis and dermatitis, but there is no record of pigmentation. Thickening of the skin was noted by Hunt, and later by Wilson (in 1873), but it was only after 1888, when keratosis of the soles and palms and other parts was first definitely drawn attention to by Jonathan Hutchinson, that this very striking effect of the administration of arsenic came to be generally recognized. Its employment in chorea is also comparatively modern. Harles (1811) merely mentions it without comment of any kind, and Martin, Salter, and Gregory seem to be the earliest writers who published accounts of cases successfully treated with it. Later Begbie and Pereira spoke very highly of its value from their own experience. In 1877 Byrom Bramwell first advocated its use in pernicious anemia.

Arsenic was first employed accurately and systematically in skin diseases by Girdlestone of Yarmouth in 1806, and in 1847 Hunt, and later Devergie, in their treatises on diseases of the skin, describe brown and gray discoloration as if this were a recognized and not uncommon incident during its administration. Hunt describes the skin as having a "dirt-brown, dingy, unwashed appearance," and Devergie uses the terms "iron-gray" and "brown." Voile (1800) says it occurs "not seldom." Since then it has been described in great detail by many writers. The color may be mottled light or dark gray, the mottling being due to irregularities in the depth of pigmentation, or it may be all shades of brown-pale, yellowish, coffee, bronze, dull coppery, or almost black. It is never equally deep over the whole surface, or even in the same area of the body, and the tint is often modified at places by hyperemia in underlying patches of the corium. Small roundish spots of unpigmented or more deeply or more slightly pigmented skin are always present, and this with the differences in color-shades gives an impression of mottling. Warty growths are often present. On the rosa of the lips and mouth the brown deposit is modified to a dark bluish color by the underlying tissues and blood, as has been previously mentioned, other instances of the same kind being the more familiar "blue line" of lead poisoning, and the bluish color of the lips in dark-skinned races.

Erasmus Wilson in 1868 gave an account of the nature of the pigment, which he describes as the ordinary melanin of the skin, and relates a case in which the eye-ball presented a "dark-tinge" in addition to deep cutaneous discoloration. But so far as Stockman has been able to ascertain the two cases which he cites are the only instances in which pigmentation of the mucous membrane of the mouth has been recorded.

More careful examination of cases in which the skin is deeply pigmented would probably show, however, that the mouth is also not infrequently involved.—(*Brit. Med. Jour.*, Nov. 10, 1923.)

Nasal Bleeding Due to a Foreign Body

(Concluded from page 269)

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